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ABSTRACT

Three projects on Elderly Abuse were established in 1980 to demonstrate improved mechanisms for reporting, investigating, treating, and preventing abuse and neglect of the elderly. A common framework for evaluation was created which allowed for comparisons and contrasts among the three projects. The evaluation objectives were: (1) to determine the nature and extent of elder abuse/neglect; (2) to assess the effectiveness of education/training/information dissemination activities; and (3) to measure the impact of the intervention model. Data collection included the assessment and re-assessment of 328 abuse/neglect cases and 49 comparison non-abuse/neglect cases; two surveys of 212 community agencies, indepth interviews with 42 physically abused elders and 42 matched control cases; and case studies of the three model projects. Using five causal factors (intra-individual dynamics, dependency, external stress, social isolation, and inter-generational transmission) as the basis for the analysis, it was shown that each type of maltreatment (physical, psychological, material, and active and passive neglect) has distinctive characteristics which may fit one theoretical model better than another. Psychopathology appears to be a major explanatory variable for elder abuse. Of lesser importance are external stress and social isolation. Not enough data could be obtained on the bakcgrounds of the perpetrators of abuse to validate the "cycle of violence" theory. In contrast to the victims of neglect who had problems with cognitive and physical functioning, which forced them to depend on their caretakers, the victims of psychological and physical abuse were more independent in meeting their daily needs, but more likely to be emotionally ill. The common denominators in cases of physical abuse were the relatively poor mental and emotional status and financial dependency of the perpetrators. Material abuse seems to be almost exclusively related to the financial needs of the perpetrators. Given these findings, exchange theory may be an appropriate paradigm for the study of elder abuse. The findings regarding the nature of elder abuse and neglect call into question policies which emphasize age-segregated service delivery (versus a family-centered/integrated approach) and which seek to shift more caregiving burdens to families without recognizing the fact that some relatives are unable to cope physically, emotionally, and financially. (NRB)

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ELDER ABUSE AND NEGLECT: FINAL REPORT FROM THREE MODEL PROJECTS

Rosalie S. Wolf
Michael A. Godkin
Karl A. Pillemer

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Rosalie S. Wolf
Michael A. Godkin
Karl A. Pillemer

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55 Lake Avenue North
Worcester, Massachusetts 01605

ELDER ABUSE AND NEGLECT: FINAL REPORT FROM THREE MODEL PROJECTS

Abstract

Three Model Projects on Elderly Abuse were established in 1980 with grants from the Administration on Aging (Title IV-C) to demonstrate improved mechanisms for reporting, investigating, treating and preventing elder abuse and neglect. By incorporating all the Project objectives into a set of three evaluation objectives and utilizing the same definitions and assessment and survey instruments, a common framework for the evaluation was created which allowed for comparisons and contrasts among the three Projects. The evaluation objectives were: 1) to determine the nature and extent of elder abuse/neglect; 2) to assess the effectiveness of education/training/information dissemination activities; and 3) to measure the impact of the intervention model.

Data collection included the assessment and re-assessment of 328 abuse/neglect cases and 49 comparison non-abuse/neglect cases; two surveys of 212 community agencies; indepth interviews with 42 physically abused elders and 42 matched control c ases; and case studies of the three Model Projects. Using five causal factors (intraindividual dynamics, dependency, external stress, social isolation, and intergenerational transmission) as the basis for the analysis, it was shown that each type of maltreatment (physical, psychological, material, active and passive neglect) has distinctive characteristics which may fit one theoretical model better than another. Psychopathology appears to be a major explanatory variable for elder abuse. Of lesser importance are external stress and social isolation. Not enough data could be obtained on the backgrounds of the perpetrators to validate the "cycle of violence" theory. In contrast to the victims of neglect who had problems with cognitive and physical functioning, which forced them to depend on their caretakers, the victims of psychological and physical abuse were more independent in meeting their daily needs, but more likely to be emotionally ill. The common denominators in cases of physical abuse were the relatively poor mental and emotional status and financial dependency of the perpetrators. Material abuse seems to be almost exclusively related to the financial needs of the perpetrators. Given these findings, exchange theory may be an appropriate paradigm for the study of elder abuse.

The percentage of cases either resolved "completely" or "a lot" ranged from two-thirds in one site to three-quarters in the other two. "Change in living/social situation of the victim" was found to have the most positive impact on case resolution whereas "reluctance of the abuser to receive help" was the most serious barrier. The services, both educational and clinical, provided by the Model Projects were rated either "excellent" or "good" by the vast majority of agencies responding to the survey.

The findings regarding the nature of elder abuse and neglect call into question policies which emphasize age-segregated service delivery (versus a family-centered/integrated approach) and which seek to shift more caregiving burdens to families without recognizing the fact that some relatives are unable to cope physically, emotionally, and financially.

Policy/Program Implications

The finding that each type of elder abuse has distinctive characteristics and theoretical explanations suggests the likelihood of multiple strategies for investigation, intervention, and prevention. Although providing services in the home to relieve the burden of caring for a disabled elderly family member or relocating that individual to a nursing home may reduce or eliminate the risk of neglect, this approach may not be a choice in cases of physical, psychological, and material abuse. It is clear that refocusing away from the stressed caregiver model of abuse can lead to a new set of possible remedies. When domestic violence against the elderly is seen to be at least partially, or equally, the problem of the abuser, the options for treatment and prevention change. Advocacy for the victim, coupled with attempts to modify the life situation of the abuser, and legal action if necessary may be the key to intervening in elder abuse cases.

This perspective also calls into question some of the existing policies regarding the care of the frail elderly. If, indeed, domestic elder abuse is essentially a family problem and is best handled by a family centered approach, then a service delivery system based on chronological age may not be the most appropriate. Also, although many relatives caring for severely disabled elderly members do so willingly and competently, the data from this study indicate that this situation does not always exist. Federal and state attempts to shift even more caregiving burdens to relatives should be studied very carefully since many family members do not have the ability to care for frail kin.

The results of the analysis of the three Model Projects indicate that to work with elder abuse and neglect cases, the organization must be able 1) to coordinate services and agencies; 2) to be flexible in its approach to practice; 3) to be creative in overcoming barriers to the delivery of services; and 4) to be prepared to fail. The staff must be well-trained and experienced in social work and case management, patient, and persistent. A friendly community environment with a well-organized human service system will enable the project to function well. If the linkages which are required for working with complex abuse/neglect cases are not present, they will have to be developed.

Finally, the importance of providing training and education about the multiple aspects of elder abuse and neglect cannot be overemphasized. So much of what has appeared in print in the past five years has been based on early studies which represented relatively few cases and which, more seriously, were methodologically flawed. These results suggest new insights into the nature of elder abuse, but they certainly have to be followed by further inquiries. There is a need to know the incidence of elder abuse, a study which would require a different methodology than was carried out here. Investigators can confidently design studies based on direct interviews with abused elders but involving abusers appears to be much more difficult. More information about the consequences of abusive acts as well as the context in which they have taken place would be helpful in planning prevention and treatment programs.

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William Neth, Program Specialist

Region II

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ELDER ABUSE AND NEGLECT: FINAL REPORT FROM THREE MODEL PROJECTS

EXECUTIVE SUMMARY

Introduction

The Model Projects were established in 1980 with three year grants from the Administration on Aging (Title IV-C of the Older Americans Act) to demonstrate improved mechanisms for reporting, investigation, treatment and prevention of elder abuse and neglect. They included the Massachusetts Department of Elder Affairs, which selected one of its affiliated home care corporations, Elder Home Care Services of Worcester Area, Inc., to carry out the program; the Metropolitan Commission on Aging of Onondaga County, New York which contracted with Alliance Division of Catholic Charities of Syracuse; and the Rhode Island Department of Elderly Affairs which chose to operate the Model Project from within the state agency. A grant for evaluating the three projects was given to the University Center on Aging at the University of Massachusetts Medical Center. The adoption of a common set of definitions and assessment instruments by the three Projects made it possible to compare case loads, organizational structures and intervention processes.

The three Projects had as their primary purpose the provision of case work services to abused and neglected elderly and members of their families. The goal was to intervene in cases of maltreatment, to introduce services when appropriate, to counsel victims and relatives, and to help resolve conflicts between abusers and abused. In addition, the Model Projects were to function as coordinators among the service providers and to be a focal point for action by local agencies on behalf of abused clients. Finally, all three had the responsibility of educating the community about elder abuse and neglect. A common framework for the evaluation was established by incorporating all Project objectives into a set of three Evaluation Objectives:

- to determine the nature and extent of elder abuse and neglect in a geographic area
- to assess the effectiveness of education/-training/information dissemination activities
- to measure the impact of the intervention model and to discuss their implications for future research, practice and policy.

The Nature and Extent of Elder Abuse/Neglect

Five theoretical explanations derived from family violence and gerontological literature served as the basis for the study of the nature of elder abuse and neglect; intra individual dynamics; dependency; external stress; social isolation and intergenerational transmission.

Three analyses were undertaken to test a series of hypotheses based on these constructs. So that the various meanings of abuse and neglect that had appeared in previous studies could be accommodated within a single definition, five subcategories were created: physical, psychological and material abuse and active and passive neglect. "Extent" was defined in terms of severity.

For the first analysis, data were collected on 328 cases by the three Model Project staff (59, Worcester; 135, Syracuse; and 134 Rhode Island) at time of intake and on 309 of the cases at the time of closure. The findings from these data indicated that the victims were more likely to be female, about 75 years of age and living in a household with family members. The perpetrator was more often a male and younger in age. The most common form of maltreatment was psychological abuse which frequently accompanied other types of maltreatment. Generally, the victims had difficulties with the instrumental activities of daily living and were in a poor emotional health. Although they were dependent in large measure on their caretakers for their daily needs, financial management, transportation, and companionship, they were relatively independent in terms of financial resources. In contrast, the perpetrators were apt to be dependent on the victims for financial support. Their lives were stressful, both from the unrealistic demands of the abused/neglected person, changes in their own health status or from financial problems. The results also showed that the abuse/neglect was very threatening or life threatening for a large proportion of victims, that the manifestations were multiple, and that the mistreatment had existed from one to two years, and in some cases, several decades.

When the 59 cases from the Worcester Project were compared with 49 non-abused/neglected cases from the same agency, several difference were noted, the most obvious was the fact that a majority of the victimized elders resided in households with family members, whereas the greater proportion of the non-abused/neglected older persons lived alone. Both the victims and the perpetrators in the abuse sample were found to have more problems with psychological and emotional health than their counterparts in the non-abuse/neglect situations. In spite of significantly greater functional and cognitive impairments, the abused/neglected elders did not appear to be more dependent than the non-abused/neglected group for most of their needs. Provocative behavior by victims coupled with unrealistic expectations and financial and medical problems of the perpetrators seemed to create a more stressful environment for the abused/neglected families than found in the non-abused/neglected sample, a situation which was further exacerbated in some instances by fewer and less frequent social contacts.

The second of the three analyses examined the relationship of the various causal factors to the five discrete types of abuse and neglect. From these results neglect was shown to be related to the dependency needs of the victims. The neglected elderly had significant problems with cognitive and physical functioning, which forced them to depend on their caretakers for many of the activities of daily living. They were likely to be more burdensome and stressful than victims of other forms of maltreatment because of a greater degee of impairment, advanced years and recent decline in mental health. In addition, perpetrators of passive neglect in the Syracuse sample had experienced stress in their own lives with the significant likelihood of having gone through a recent divorce or separation. A tendency towards social isolation, associated with loss, was also a factor in the Worcester cases of passive neglect which revealed a significant number of perpetrators without an emergency contact.

In marked contrast to cases of neglect, the victims of psychological abuse were relatively unimpaired, cognitively and functionally, and more independent in meeting their daily needs, but more likely to be emotionally ill. Psychological abuse appears to be related to the mental health of the participants and the pathological interpersonal relationship which exists between them. The data from both the Worcester and Rhode Island cases indicated that the victims of psychological abuse were more likely to have poor mental health. Also, transactions between victims and perpetrators were likely to involve pathological behavior by the latter. In fact, a tendency for perpetrators at one site to have unrealistic expectations suggests that some psychological dependency on the elderly victim may exist. Indirectly, this finding was supported at a second site where a significant number of perpetrators of psychological abuse were provocative in their behavior towards their victims.

Material abuse seems to be nearly exclusively related to the financial needs of perpetrators, although social isolation of the victims may have been a contributing factor in the other two sites, since the data show that the victims at one site were more likely to have suffered recent losses in their social network and the Rhode Island victims tended to be unmarried. The perpetrators of material abuse were generally distant relatives or non-relatives, who were not emotionally involved with their victims and appeared to be motivated by greed.

In cases of physical abuse the two common denominators in all three sites were the relatively poor mental and emotional status of the perpetrators and the shared living arrangements of victim and perpetrator. Interpersonal pathology was also a factor in these cases.

Further insight into the dynamics of these situations was provided by a case control study of 42 physically abused victims and matched non-victims, the third analysis. When the cases were compared with the controls on psychological factors, they were much more likely to have mental or emotional problems, to abuse alcohol, and to have been hospitalized for psychiatric reasons. The results on the dependency criteria indicated that abused elders were not in poorer health or more functionally disabled than the control group; in fact, they were less disabled in a number of areas. The abuse group was not more dependent on their kin than the comparisons for assistance with activities of daily living, but the perpetrators were more likely to be dependent on their elderly victims than were the control relatives.

Of the life events used to measure stress, three were more likely to be associated with the abused families (someone moving in, someone leaving, and someone getting arrested). Rather than true external events, these actions could be attributed to the perpetrator and the abuse situation. No other stress items differentiated the two group. On three of the five social resources scales, the abuse cases scored more poorly than the comparison group. They had fewer overall contacts and were less satisfied with those they did have. Findings for intergenerational transmission of abuse were not significant. Abused elders did not report more physical punishment of children nor did they indicate that the perpetrator had been a victim of child abuse.

Effectiveness of Education/Training

Findings from two surveys of community agencies were used to assess the effectiveness of education/training activities of the Model Projects. According to the results of Survey II (n=212), about half of the community agencies that responded (somewhat less in the Worcester area and more in Rhode Island) had attended at least one program on elder abuse/neglect in the preceding two years, and the Model Projects had sponsored a large majority of them. Ratings for their programs were either "excellent" or "good." Inservice education was the most often mentioned format.

In spite of the high case loads and limited staff, the Model Projects were able to sponsor a variety of educational programs, provide technical assistance and information, and conduct innumerable inservice programs. Nevertheless, the results showed that there were many agencies and individuals involved with older people, that did not benefit from the information and training. In addition to the assessment of the above Model Project training and educational programs, the evaluation team arranged for the dissemination of findings through the publication of a manual* for persons working with abused elders and the organization of workshops and the presentation of papers at more than two dozen national and regional meetings in the three year period.

The Impact of the Intervention Models

Three criteria were selected to measure the impact of the intervention model: case resolution, community response, and model replicability. The case assessment and re-assessment forms completed by the Project staff furnished the data to compare the status of the victims, perpetrators, and abuse/neglect situations at intake and at the close of the case; community surveys conducted two years apart provided the statistics on community awareness and Project performance; and interviews with the Project and community agency personnel yielded the information on the organizational models.

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*University Center on Aging, Working With Abused Elders: Assessment, Advocacy and Intervention Worcester, MA: University of Massachusetts Medical Center, 1984.

Case Resolution

All the Projects recorded a large decrease in the number of manifestations of abuse and neglect and their severity, and a significant reduction in the level of threat which they posed for the victim, between case intake and closing. They also made progress in reducing the degree of dependency of both the perpetrator and the victim regarding various instrumental activities of daily living and improving the quality of the relationship between the victim and the perpetrator. The staff of two of the Projects also noted significant improvement in the emotional state and self esteem of the victims and the level of stress on the perpetrators. Two-thirds of the Worcester cases were rated as either "resolved" or resolved "a lot" compared to three-quarters for Syracuse and Rhode Island, which was a significant difference. For slightly less than half of the cases, the elimination of violence resulted from separation of the victim and the perpetrator through nursing home placement, death, hospitalization or relocation into new community residences. In fact, "change in living/social situation of the abused/ neglected" was chosen from among several strategies by all three Project staff as having the most positive impact on case resolution.

Community Awareness

By the end of the grant period, slightly more than half of the agencies responding to the Survey (II) were aware of the problem of elder abuse and neglect and somewhat less than one-third were aware but had not encountered a case. Fewer than one out of two of the community groups had specific procedures to deal with cases and of these, less than half were in writing. A small percentage in all localities were not aware of such situations. These proportions are similar from those of the first Survey (I) conducted at the beginning of the grant period. Because of the change in wording in the two questionnaires and the different group of respondents, no comparisons can be made as to the impact of the Model Projects in increasing community awareness. It appears that most agencies in the community were aware of elder abuse before the establishment of the Projects.

Over the two year period, however, there was a change in the community response system with a larger proportion of agencies naming the Model Projects as the resource they would turn to or had turned to with cases of abuse/neglect. The social service and health agencies were more apt to refer directly to the Model Projects while the police, legal and mental health groups and some state agencies usually investigated the situation first and then referred if the case warranted it. In two of the sites, the Model Projects were the major referral units for elder abuse and neglect; in the third, it a shared responsibility between the Model Project and the Adult Protective Services unit of the County Department of Social Services. The quality of the services provided by all Model Projects was rated as either "excellent" or "good" by the vast majority of community agencies that answered the survey (II), with special commendation for the promptness of the response.

Although all three Project were responsible for helping to establish services in their localities the impact of this activity could not be documented from the survey data. Respondents to the first survey produced a long and varied list of service needs, but, except for emergency shelter and respite care, each one was mentioned only a few times. On the second survey, the question was answered by only one-quarter of the responding agencies, and again no resource was cited more than three or four times. From the perspective of the community agencies, there appeared to be no real service gaps, although in the case assessments, the Project staff in one site noted that they were hampered by scarcity of some services (particularly respite care); in another, by non-reimbursement of certain services; and in the third, by lack of protective services.

Model Replicability

The Projects, although similar in goals, target population, staffing and operational definitions, represented various approaches to elder abuse/neglect intervention. The Worcester Project was located in an agency where the case workers had the authority to order a wide range of social services and thus was designated as a "service brokerage" model for its clients. The Syracuse Project, on the other hand, functioned primarily as a coordinator of services supplied by other agencies and were termed a "coordination model." It did however have direct control over a group of aides who worked with the most difficult cases. The Rhode Island Project ("mandatory reporting model" had access to some direct services sponsored by the Department of Elder Affairs, but was also dependent on community agencies to assume responsibility for the cases once the situations had been investigated and the abuse alleviated. Consequently, a great deal of the Rhode Island staff efforts were spent in working with community agencies and coordinating care plans. Also, because of the mandatory reporting, the agency, unlike Worcester and Syracuse, was under pressure to respond to all calls within a certain time allotment.

Because of the variations in function and structure, the Project faced different problems in developing and implementing their programs. For example, the Worcester Project resolved an intra-agency problem by devising a plan of "co-management" so that the case managers in the agency could remain in charge of their abuse cases but also call on the Model Project staff for advice and direction. Similarly, the Rhode Island Project handled an intra-agency problem with its information and referral workers by training all of them to accept elder abuse/neglect reports rather than having all such calls referred to a separate I&R worker. All three Projects worked out formal and informal procedures for promoting interagency coordination. To facilitate the process, the Syracuse Project organized a "team" representing the relevant service providers for each case which met at intake and then as necessary to follow its progress. Rhode Island made use of key councils, groups of elder service providers in the local communities, that met regularly to discuss common cases. Both the Syracuse and Rhode Island Projects avoided conflict with their local Adult Protective Services units, which were also charged with responding to cases of abuse and neglect, by showing their willingness to take on the most difficult cases.

An analysis of the use of time by the Project staff indicated that the Worcester social worker spent about four times as long in direct service to clients (interviews, home visits, etc.) than did the social workers in the Syracuse and Rhode Island projects. This finding highlights the difference between the case management approach of the Worcester Project and the "assessment, coordination and referral" process utilized by the other two programs.

In analyzing the Model Projects for replication certain facts stand out: the circumstances of both the Worcester and Rhode Island Projects are unique. Massachusetts, unlike any other state, has the extensive network of home care corporations which provide case management and social services to all frail elderly who meet the eligibility requirements (in FY84, 43,400 elders were served at a cost of $84 million in state funds). Prior to the demonstration, the Worcester agency had established a crisis intervention program to handle the protective service cases. It was the opinion of the agency administration that these cases required more highly skilled case workers, smaller case load and better trained homemakers than the usual clientele. This was not, however, the only model in use by home care corporations in Massachusetts. One of the tasks of this study was to compare two other programs, one in which the protective services component was contracted out to family service agencies; the other in which the abuse/neglect cases were assigned to the regular care managment staff as part of their case load. After an analysis based on referral patterns, case coordination, service utilization, and management, the Worcester Model was judged the most efficient for the home care system and has since the end of the grant period been put into operation throughout the state.*

Because of the special nature of the home care agencies, it would not be realistic to recommend the Worcester Project as a national model for dealing with cases of abuse and neglect over the other two Model Projects. Although it was rated highly for performance and coordination by the community, its client-staff ratio was considerably smaller than the other two programs, and, at least, in the perception of the Project staff, slightly less successful in resolving the cases. Rhode Island also represents a special model. As part of a state agency which is both a state unit on aging and an area agency on aging, it did have considerable leverage in working with other state agencies and the local communities. According to the response from community agencies, however, it was less effective than either of the other two projects in coordination and performance, more than likely due to the large number of calls it had to respond to under mandatory reporting legislation and the normal tension which exists between the state and local groups.

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*In the third year of the grant, elder abuse legislation was passed by the Massachusetts General Court and reporting of elder abuse/neglect cases was made mandatory. There is now in each home care corporation a protective service specialist. Unlike some states, the Massachusetts Adult Protective Services division of the Department of Public Welfare only handles clients under 60. Responsibility for those 60 years and over has been given to the Department of Elder Affairs.

Of the three Projects, the Syracuse model stands out as the easiest to replicate. Its record, regarding case load and resolution, was similar to that of the Rhode Island Project, but is efforts at coordination of services were viewed more positively by community agencies. Using the team conference as a coordination strategy, the Syracuse project was able to involve local service providers in the case management process and the local Adult Protective Service unit (mandated by the state to respond to reports of elder abuse and neglect) in a way which avoided issues of territoriality and conflict. Although it did not have control over a range of services as did the Worcester Project, it did employ a group of aides who assist in coordination and communication among the staff, clients, and service providers. Because no special sponsorship is needed, such as a home care corporation or a state or area agency on aging, any human service organization can adopt the program. This flexibility as well as the success in case resolution, the high case-staff ratio, and the effectiveness in coordination make the Syracuse project a particularly attractive model for replication.

Conclusions

The most clear-cut finding of the evaluation study is that elder abuse/neglect cannot be described by a single set of factors or explained by one theory. Rather, each type of maltreatment (physical, psychological, material, neglect) has distinctive characteristics which may fit one theoretical model better than another. Given the complexity of the circumstances surrounding these cases, this finding may not be surprising. Many factors are at play: the physical and psycho-social status of the protagonists, family dynamics, the environment, the culture in which the individuals were raised, and the economic situation. Yet, when searching for a theoretical explanation for elder abuse and neglect, sociologists and gerontologists have tended to concentrate on one paradigm. The value of acknowledging the differences of each type of abuse will help practitioners and program planners in the development of preventive and intervention strategies and, particularly in identification of persons at the greater risk.

Another finding which has emerged from the data is that psychopathology is very evident in cases of psychological abuse and to a lesser degree, physical abuse. Contrary to the minor role which it is given in the family violence literature, psycho-pathology appears here to be a major explanatory variable for elder abuse. Whether this is due to the fact that the cases which come to the attention of the formal service network are more likely to be psychopathological in nature than those which exist in the general population cannot be determined in this study. It does suggest, however, the need to carry out community based population surveys not only to determine the incidence but to learn more about the phenomenon and its variations. If indeed psychopathology is as an important risk factor as it seems and not the results of a methodological bias, then the origins of elder abuse by adult children may be quite different than that of the spouse or child abuse model now generally accepted. A third finding of the study is the noticeable lack of support for the sociological factors of external stress and isolation. Although present in the situations of the various types of abuse/neglect, they merely seem to exacerbate the situations rather than cause them directly. Again, these results may be byproducts of the research design and certainly should be investigated further.

The results of the evaluative research also suggest that the relationship of dependency to elder abuse/neglect found in the gerontological literature needs to be re-examined. The victim as a very old, increasingly functionally disabled woman, totally dependent on an overburdened, neglectful, or abusive adult child is characteristic of neglect in this study, but not abuse. In cases of physical, psychological and material abuse, dependency takes on another form. Not only is the victim dependent on the perpetrator but perpetrator is dependent on victim. Given these findings, exchange theory may be an appropriate conceptual framework in which to study forms of abuse. The exchange paradigm suggests that as dependencies increase, the cost of the relationship to the caregiver become greater, the rewards diminish, and the exchange is perceived as unfair. The perpetrator acts out of a sense of powerlessness.

Implications for the Study of Elder Abuse

As noted earlier, exchange theory has been useful in explaining the results of these analyses. Certainly, conflict was very much in evidence in the families under study. Sometimes, this conflict appears as overt violence, and at others as extreme verbal aggression. There is also a need to apply another type of theory to the aging family. As the evidence mounts, elder abuse comes more and more to look like a another social problems: violence against women carried out predominantly by men. Much feminist research (Walker, 1984) has placed spouse abuse in the context of the patriarchal nature of American society, and has insisted that male dominance be seen as a causative factor. In this study, all but three of the victims were woman, and the three men were all abused by sons. Woman in the sample were more likely to be abused by sons, husbands or brothers than by daughter or daughters-in-law. Future researchers should attempt to extend feminist principles to the area of elder abuse. This would not only aid us in understanding maltreatment of the elderly, but would also provide an important new testing ground for feminist theory.

In essence, these proposals for greater use of conflict and feminist theory point to the same thing: researchers in family gerontology should move beyond the consensus model that has thus far guided research in this area, beyond evidence such as physical proximity of kin and frequency of visitation to studies of the quality of relationships. The notion that the kin of the elderly always approach them with the best intensions may not be always true. Conflict, rather than consensus, may be the main dynamic in the aging relationships.

Implications for Practice

The combined weight of the quantitative and qualitative evidence reported here show a strong association between the dependency of the abuser and maltreatment. The victims perceived themselves as being on the losing end of the exchange. Previous research which has attributed abuse to the demands of the older individual has tended to blame the victim; the findings reported here suggest refocusing on the perpetrator.

An emphasis on the problems of the abuser would have important implications for service planning. Many states are developing protective services programs to intervene in cases of elder abuse, and some (32 to date) have instituted mandatory reporting laws. In order to implement such statutes, the protective service function must be expanded even further. A dilemma facing every new program is that of case identification. Who are the most vulnerable elderly? Previous attempts to identify older persons at high risk of abuse have been colored by the assumption that the dependency of the victim causes maltreatment. If the findings reported here are substantiated by future research, an additional risk category can be identified: situations in which relatives (especially children) live as dependents with the older person. Elder abuse workers and other professionals should pay special attention to such cases.

Based on the hypothesis that elderly dependency leads to abuse, supportive services to caregivers have been offered, such as self help groups. In many cases of elder abuse, an attempt is made to introduce home care services, such as house cleaning and meal preparation, to receive the "burden" of caregiving. Although such services may play a role in preventing or ameliorating abuse situations, the present study shows a need for other services as well. Exchange theory offers an approach to intervention. Either the rewards of reducing dependency on the elder can be increased or the costs of abusing the victim can be heightened. To achieve the former goal, unhealthy dependence of an older person could be reduced through psychotherapy, employment counseling, and financial support for the abuser while he or she establishes an independent household. In some case the change in living situation may be a nursing home placement for a dependent, abusive spouse.

The costs of abusing an elderly person can be raised in a variety of ways. They might include increasing social support for the elderly so that they will become able to say: "I will not take this anymore!" or assuring that outsiders (e.g., senior companions, friendly visitors, etc.) are present in the homes where abuse occurs. "Safe houses" and emergency shelters are other possibilities that could be used for the elderly.

A final alternative is legal action. Clearly, when elder abuse was conceived of as occuring because of caregiver strain, involving the police rarely semed necessary. In the new conceptualization put forth here, elder physical abuse is seen as having parallels to spouse abuse; relatively independent people sharing a residence with the physically stronger one victimizing the weaker. In fact, legal action may be especially appropriate in elder abuse cases, as so many seem to have an element of financial exploitation.

It is clear then that a refocusing away from the stressed caregiver model of abuse leads to a new set of possible remedies. When domestic violence against the elderly is seen to be at least partially or equally the problem of the abuser, some combination of the above service programs appears to be indicated. Advocacy for the victim, coupled with attempts to change the life situation of the abuser, and legal action if necessary, may be the key to intervening in elder abuse cases.

Several implications for practice can be drawn from the analysis of the Model Projects and their impact in the community. Important elements in the success of any program are the organizational structure, the staff, and the environment. To work with elder abuse and neglect cases, the organization must a) be able to coordinate services and agencies; b) be flexible in the approach to practice; c) be creative in overcoming barriers to the delivery of services; and d) be prepared to fail. The staff must be well trained, patient, and persistent. A friendly community environment with well organized human service system will enable the project to function well. If the linkages which are required for working with the complex abuse/neglect cases are not present, they will have to be developed.

It is important that valid and reliable information about elder abuse and neglect be made available to people in the aging field as well as others who may in some way be involved in the problem. So much of what has appeared in print in the past five years has been based on early studies which represented relatively few cases and which, more seriously, were methodologically flawed. Almost every national, regional and state meeting dealing with problems of the aged has included at least one session about elder abuse, but the audiences tend to be relatively small with limited dissemination of materials. Even the concerted efforts made by the Model Projects reached only a portion of the community and human service providers.

There is now a network of agencies in most states established to respond to reports of abuse and neglect at the local level. The likelihood is that before long, most if not all the states will have laws governing the reporting and investigating of elder abuse situations programs, service requirements, immunity and competency. Many social and legal services, health and mental health facilities, the police, courts, and churches are, or will be, involved. For all of these groups, education and training about the issues involved in elder abuse and neglect will be vital.

Implications for Policy

Of the various groups which are involved in treating abuse cases (e.g., hospital teams, legal services, home health agencies, mental health centers, etc.), the social service agency apppears to be most suitable for carrying out the case management function and coordinating the many services which are necessary. A family systems approach may be the most successful since abuse/neglect situations often involve several family members, spouses, children, grandchild, and other relatives. Most of the states with elder abuse protection laws have elected to place their protective services units within the departments of social services rather than in the state units on aging. Under these circumstances, there is the possibility that the older adults may be subject to age discrimination or at least receive inadequate attention. On the other hand, placing the elder abuse program within the aging network may require that the organization invest time and resources in working with non-elderly family members. These issues raise the question of the appropriateness of an age segregated versus an age integrated service delivery system.

Another policy issue concerns family responsibility for the elderly. Many relatives, caring for severely disabled elderly members, do so willingly and competently. The data on the abuse group here describe families in trouble. Federal and state attempts to shift even more caregiving burden to relatives should be studied very carefully. Such plans range from providing a tax credit or direct payment to persons caring for aged kin in their home, to actually making children liable for the costs of thier parents' nursing home care. Based on these data, such a shifting of responsibility should be done only with great caution. Put simply, many family members do not have the ability to care for frail, impaired older persons. It is difficult to imagine many of the abusers in this study doing so. Policies that place the elderly in the hands of such individuals must be pursued with care. Of course, concommitant with any such steps must be the provision of protective services.

Implications for Research

This project has provided a number of useful findings for researchers. Investigators can confidently design studies based on direct interviews with abused elders, rather than relying on professional accounts of abuse. Including abusers may be much more difficult. A major disappointment in the physical abuse study was the failure to obtain an abuser sample. Attempts should be made to reach this group; their perspective is also needed to understand the situations. The importance of a control group in elder abuse research also cannot be over-emphasized. Since research in other forms of family violence indicate that the cases that reach an agency tend to be the most severe, studies should move away from agency samples to general population surveys.

Investigators should pay more attention to the context of abusive acts than was possible in this study; also to the consequences of abuse. Several topics for future research have been suggested by these findings including why abusive children come to live with their parents; how child rearing practices in terms of dependency affect parent-adult child relationships in later life; and what role alcoholism plays. More specifically related to the evaluation study itself would be further investigation into the concept of "case resolution." A simple definition of "alleviation or elimination of maltreatment" which was utilized in this project may not be adequate, especially when the victim does not wish to be separated from the perpetrator. Also, a follow up study of the Model Project cases should be undertaken to compare the long range effectiveness of the interventions. Finally, the findings of the study produced a series of risk factors which formed the basis for the design of an instrument for the identification and assessment of abuse/neglect victims. Additional studies are necessary to test their validity and reliability.

CHAPTER ONE

INTRODUCTION

A. Purpose

In the summer of 1980, guidelines for the Title IV-C Model Projects were issued by the Administration on Aging, designating elder abuse and neglect as one of the priority demonstration areas. Over two years had passed since University of Delaware researcher, Suzanne K. Steinmetz (1978) first startled the House sub-committee with her report on "battered parents". Evidence from the early studies and the investigation by the House Select Committee on Aging which followed Dr. Steinmetz's testimony indicated that elder abuse was occurring nationwide and that the incidence was increasing. Although these research efforts provided documentation about the characteristics of the victims, perpetrators and abuse/neglect situations, they offered insight into the the causes and specific dynamics of the abuse/neglect situation. Because of the sense of urgency associated with the problem, the Administration on Aging allocated a portion of its 1980 discretionary funds to support several Model Projects. Their primary purpose would be:

- to determine the extent of elderly abuse in a geographic area;
- to develop knowledge of existing responses;
- to demonstrate improved mechanisms for reporting and investigating treatment and prevention; and
- to design social and legal remedies to restore the rights and well being of abused elderly;

and, secondarily,

- to increase public awareness of the prevalence of the problem;
- to improve reporting to authorities; and
- to institute community wide programs utilizing existing public and private sector services to reduce the incidence of abuse.

The study and treatment activities would be limited to the abuse and/or neglect of persons 60 years and older by informal care givers in domestic settings.

B. Model Projects on Elderly Abuse

Of the many organizations that responded to the request for proposals issued by the Administration on Aging (AOA), four were selected for funding: the Boston Commission on Affairs of the Elderly, the Massachusetts Department of Elder Affairs, the Metropolitan Commission on Aging of Onondaga County (NY), and the Rhode Island Department of Elderly Affairs. Rather than support two separate projects in Massachusetts, the AOA, after negotiations with the Boston Commission and the Department of Elder Affairs, approved a revised version of the Massachusetts proposal, which incorporated the major elements of the Commission's program. A brief description of the Projects and their objectives are given below.

Massachusetts Department of Elder Affairs

The Massachusetts Department of Elder Affairs had been engaged in both the study and treatment of the problem for several years. In 1978, it financed a state survey of professionals and paraprofessionals on the maltreatment of elderly. Conducted by Legal Research and Services for the Elderly of Boston (O'Malley, Segars, Perex, Mitchell, and Kneupfal, 1979) the survey documented the existence of elder abuse in the state. The Department also supported a community based agency, Elder Home Care Services of the Worcester Area* that had developed a crisis intervention program which served abused elders.

According to the Massachusetts proposal, two models for service delivery would be tested: one, a special elder abuse unit organized within the Elder Home Care Services of Worcester Area (EHC), which would extend the agency's case management capability to include interagency agreements for 24 hour response, temporary shelter, family counseling and other needed services. The other would be a coordinated elder abuse response system created by the Boston Commission on Affairs of the Elderly, which would include a hot line, case planning protocol, and identification and funding of "gap filling" services. A team from the Center on Aging at the University of Massachusetts Medical Center (UMMC) would serve as project evaluators. The objectives of the Massachusetts program were:

- to plan and develop coordinated elder abuse and neglect programs in the cities of Boston and Worcester, to include health, mental health, social and legal services, housing and to include services to abusers as well as abused and neglected elders;

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*Elder Home Care Services of Worcester Area, Inc. is one of 27 nonprofit corporations located throughout Massachusetts which provide home-based social services (homemaker, chore, transportation, etc.) to eligible persons 60 years and older. Funds for the programs are provided by the state through the Massachusetts Department of Elder Affairs. "Home Care Agencies" or corporations when used later in this text refers to these special agencies.

- to develop and implement a training program for provider agencies and direct service workers;
- to evaluate the activities and results of the entire project and the site activities in the two cities; and
- to disseminate project information and results nationally and within the Commonwealth.

Metropolitan Commission on Aging of Onondaga County (NY)*

The Commission proposed to design and implement a comprehensive and coordinated service system building on the existing community human service infrastructure. For administrative and operational purposes, the project would be sub-contracted to Alliance, a local affiliate of Catholic Charities of Syracuse with experience in the delivery of comprehensive and coordinated services for the treatment of child abuse. The objectives as specified in the Commission's proposal were:

- to work with the community's socio-legal system for the development of comprehensive and coordinated network for the prevention and treatment of elderly abuse;
- to develop and facilitate linkages for the utilization of prevention and treatment services through comprehensive and coordinated educational efforts;
- to initiate service intervention for the prevention and treatment of elderly abuse;
- to design, develop and implement a data system for the gathering of information on the pre valence of abuse, predictors of abuse, and the utilization and effectiveness of service delivery; and
- to develop and organize these activities neces sary to establish an organizational entity for the administration and operation of the project and to engage in those activities to ensure ongoing organizational and programmatic functioning.

Rhode Island Department of Elderly Affairs

As both a statewide Area Agency on Aging and a State Unit on Aging, the Rhode Island Department of Elderly Affairs (RI-DEA) provided an opportunity to demonstrate a state-wide comprehensive response system for elderly abuse. In its application to AOA, the Department proposed to develop a data base documenting the prevalence of elder abuse, to increase public awareness, to provide coordination and linkages for a reporting system and to offer counseling and assistance to the abused and abuser. A series of program tasks were set forth as their objectives:

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*called "Syracuse Project/Site" in the text

- Increase community sensitivity to the problem of elderly abuse by utilization of the media;
- Develop and present to elderly groups a play concerning elderly abuse;
- Provide a hot-line service for any Rhode Islander who wishes to report a possible elderly abuse case;
- Provide domestic violence training to aging net work personnel, law enforcement personnel, and other social service agency personnel;
- Provide emergency shelter to elderly who are victims of abuse and who may need immediate care;
- Provide counseling and intervention to elderly abuse victims or potential abuse victims and their abusers;
- Provide outreach to all reported cases of sus pected elderly abuse;
- Develop inter-agency coordination and community linkages to maximize the delivery of quality and cost efficient services;
- Encourage and assist in the development and implementation of temporary live-in shelters for elderly who are victims of abuse, and
- Develop a research instrument to measure the type and incidence of abuse among the elderly.

For the most part the Model Projects are located in urban settings with higher than the national average elderly populations. The service area of Elder Home Care encompasses the City of Worcester and 15 surrounding towns, part suburban and part rural with 51,904 persons 60 years and older, or about 18.4 percent of the total population. The City of Boston, the second site for the Massachusetts Department of Elder Affairs Model Project has 95,262 individuals 60 years and older comprising 17.0 percent of the city population. Onondaga County, the locale of the Alliance second Model Project, which includes the city of Syracuse, is inhabited by 71,792 60 year olds representing 15.5 percent of the county populace while the third Model Project encompasses the entire state of Rhode Island and 176,373 adults 60 years and older or 18.6 percent of the state citizenry.

C. Evaluation Plan

Although the proposals from the Metropolitan Commission on Aging (Syracuse) and Rhode Island Department of Elderly Affairs contained references to the development of a data system and collection of information on prevalence and incidence of abuse, only the Massachusetts Department of Elder Affairs application included an evaluation plan. Prepared by a team from the Center on Aging of the University of Massachusetts Medical Center (UMMC), this component was designed to answer a series of researchable questions, derived from the project propositions and objectives:

- What are the nature and extent of elder abuse in the geographic areas?
- What is the impact of the outreach and case finding techniques on the reporting of elder abuse cases in the geographic areas?
- What is the impact of the Model Project on elder abuse in the geographic area?
- What is the impact of the dissemination of information from the Elder Abuse Project in the state and nationally on the development of pro grams dealing with elder abuse?
- Is the Model Project a viable and replicable model?
- Is the Model Project an efficient model?

With the inclusion of the Boston site*, the plan was expanded to provide information about elder abuse in the city of Boston and to assess the impact of a coordinated response system to be developed by the Bostom Commission on Affairs of the Elderly.

At a meeting of all the Model Project Directors in Boston, called by the Region I AOA office early in 1981, the evaluation team presented their preliminary forms and definitions. The interest of the Syracuse and Rhode Island staff in using these materials led to the development by the UMMC team of a single evaluation methodology for the three Model Projects. A common evaluation framework was created by incorporating all project objectives into a set of three Evaluation Objectives:

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*At the end of the first year of the grant period, the Boston component was not re-funded by the Administration on Aging. The results of the evaluation efforts in Boston can be found in Rosalie S. Wolf, Cecile P. Strugnell, and Michael A. Godkin. "Preliminary Findings From Three AOA Model Projects," Worcester: University Center on Aging, University of Massachusetts Medical Center, 1982; a discussion of the program's progress can be found in the Appendix II, Exhibit 1.

- to determine the nature and extent of elderly abuse in a geographic area;
- to assess the effectiveness of education/training/information dissemination activities; and
- to measure the impact of the intervention model.

Fourteen tasks were carried out to achieve these objectives:

1. Survey of Community Agencies in Four Sites 1981
2. Individual Cases Reported by Community Agencies in Two Sites
3. Evaluation of the Boston Site
4. Organizational Assessment of the Delivery of Protective Services to Abused and Neglected Elders at Two Home Care Corporations.
5. Assessments of Cases Reported by the Three Model Projects
6. Assessment of Non-Abuse Cases (Comparison Group) From One Model Project
7. Qualitative Analysis of Selected Physical Abuse Cases
8. Re-Assessments of Cases Reported by the Three Model Projects
9. Survey of Community Agencies in Three Sites 1983
10. Organizational Analysis of the Three Model Projects
11. Indepth Analysis of Physical Abuse Cases
12. Evaluation of Training Programs for Protective Services Workers
13. Development of an Assessment Instrument for Use By Protective Services Workers
14. Manual on Elder Abuse/Neglect for Service Workers

Since this study builds on the work of previous investigators, the next chapter of this document is devoted to a review of the past major studies on the problem, a discussion of some of their limitations, and a presentation of some of the proposed theories of causation. The Methodology and Results for each of the above tasks* follow in Chapters Three to Nine. A concluding Chapter will summarize the Report and discuss future programmatic, practice and policy considerations.

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*The Methodology and Results for tasks 1,2,4, and 11 are given in separate reports and will not be repeated here. See Rosalie S. Wolf, Cecile P. Strugnell and Michael A. Godkin, "Preliminary Findings from Three AOA Model Projects," Worcester: University of Massachusetts Medical Center, 1982; Appendix II, Exhibit 1; Karl A. Pillemer and Rosalie S. Wolf, "Organizational Assessment of the Delivery of Protective Services to Abused and Neglected Elders at Two Massachusetts Home Care Corporations," Worcester: University of Massachusetts Medical Center, 1983; Appendix II, Exhibit 2; Working With Abused Elders Assessment Advocacy and Intervention Worcester: University Center on Aging, University of Massachusetts Medical Center, Worcester, MA 1984. The full reports on tasks 3 and 7 can be found in the Appendix II, Exhibits 3-4.

CHAPTER TWO

LITERATURE REVIEW

A. Findings from Earlier Studies

A summary of the five studies, which played a major role in defining the problem of elder abuse are introduced in this Chapter. Although limited in terms of conceptualization of the problem and methodology they do substantiate the existence of elder abuse, offer some theoretical basis for its occurrence, and provide examples of prevention and treatment procedures. Three more recent research efforts published after the initiation of this evaluation are also included, followed by a comparison and critique of these findings. The Chapter ends with a discussion of the most plausible, theoretical explanation of abuse and neglect drawn from the sociological, gerontological, and family violence literature.

Lau and Kosberg Study

In a paper, "Abuse of the Elderly by Informal Caregivers", Elizabeth Lau and Jordan Kosberg (1978) describe an exploratory study of elderly clients of the Chronic Illness Center in Cleveland, living in the community, who were victims of abuse by family or surrogate family members. The retrospective search of records for a 12 month period by agency workers revealed that there were 404 clients 60 years and older, of whom 39 or 9.6 percent were victims of abuse. Their definition of abuse included physical abuse (beating, withholding personal care, food and medical treatment; and lack of supervision); psychological abuse (verbal assaults and threats, provoking fear and isolation); material abuse (monetary or material theft or misuse); and violation of rights (being forced out of one's dwelling or into another setting).

Physical abuse was the predominant type of maltreatment in their sample, occurring in 74 percent of the cases, compared with 51 percent for psychological use, 31 percent for material abuse, and 19 percent for violation of rights, which usually accompanied other forms. The victims were predominantly female (77 percent), and three quarters suffered from at least one major physical or mental impairment. Among the abusers, 27 percent were daughters, 16 percent sons and granddaughters and 15 percent, husbands. Twenty nine percent of the clients accepted professional assistance; 26 percent refused help. The remaining 47 percent were eventually institutionalized. The authors state the need to obtain the most accurate and complete information about a suspected abuse case and to establish a positive relationship as the first steps in the intervention process. Counseling, engagement of other relatives or homemakers, regular nursing and medical care can help reduce the stress in the household for the abused and abuser and assist in maintaining the elderly person in the community.

Block and Sinnott Study

The results of a second study were published by the Center of Aging at the University of Maryland in a report entitled, "The Battered Elder Syndrome: An Exploratory Study". Edited by Marilyn R. Block and Jan D. Sinnott (1979), it included a comprehensive review of the literature on intrafamily violence and a discussion of its applicability to elder abuse, and the findings from three surveys undertaken in the Baltimore-Washington, D.C. area to determine the feasibility of different approaches to investigating the nature and extent of elder abuse.

Three different groups were surveyed by mail: community agencies; a random sample of elders living in the community; and individual professionals, such as nurses, doctors and social workers. The response rate in all three groups was low: only one agency out of 24 responded, while 16 percent of the community dwelling elders and 31 percent of individual professionals returned the forms. These efforts yielded a final total of 26 cases, for whom the individuals surveyed filled out case reports.

Abuse in this study is also categorized into four types: physical, psychological, material and medical. The latter is defined as withholding of medicine or aids, such as eye glasses or false teeth. Using information from their mail surveys of professionals and community elders, these investigators found abused elders to be generally 75 years or older and female (81 percent). Almost the entire sample (96 percent) had some physical incapacity related to activities of daily living, and about one third (35 percent) had moderate mental impairment. Fifty-eight percent of the cases belonged to the middle class. The abusers were often relatives, female rather than male. Forty-two percent were children, including in-laws, and 15 percent were spouses. Psychological abuse (58 percent) was more common than physical (38 percent), but almost half the group (46 percent) were victims of the misuse of money or property.

In their discussion of intervention strategies, the authors note that action may involve social services, civil sanctions and criminal proceedings. The most frequent referral for their cases was a public social service agency. They also emphasized a thorough investigation of the complaint as the first step in confirming the existence of the problem and determining the course of action to follow. While institutionalization, they added, may be the least favorable social service intervention, there are cases where removal of the victim from the home situation is the only solution.

O'Malley et al. Survey

A third study, "Elder Abuse in Massachusetts: a Survey of Professionals and Paraprofessionals", prepared by the staff of Legal Research and Services for the Elderly (O'Malley, et al., 1979) presents information about the victim of abuse, the perpetrator and the abuse situation as well as the professionals who encounter it and their responses. The findings were based on a survey of 1044 professionals requesting information on abuse cases for the previous 18 month period. About one-third of the group responded (355), citing 183 cases.

Abuse in this study is defined broadly to include willful infliction of physical pain, injury or debilitating mental anguish, unreasonable confinement or willful deprivation of services which are necessary to maintain mental and physical health. The typical victim was found to be over 75 years of age rather than between 65 and 75, and female rather than male. Three-quarters of the cases had mental or physical performance decrements related to activities of daily living. Abusers were relatives in 84 percent of the cases. Almost three-quarters of the respondents stated that the abusers were experiencing some form of stress such as alcoholism, drug addiction, long term medical complaint or financial difficulties. Over 41 percent of the reported abuse involved physical trauma, including bruises, welts, cuts, and punctures, while mental anguish accounted for 24 percent.

According to the information supplied on the 183 cases, the agencies employed a variety of actions. In half the cases, referrals were made to other service agencies and in one-fifth, action was of an emergency nature. The single most often cited action was removal of the victim, either placement in another setting or hospitalization, which occurred in almost 22 percent of the cases.

Douglass, Hickey and Noel Study

Authored by the University of Michigan Institute of Gerontology research team of Richard L. Douglass, Tom Hickey and Catherine Noel (1980), "A Study of Maltreatment of Elderly and Other Vulnerable Adults" contains the results of a survey of direct service practitioners regarding their experience and practice with elder abuse and neglect in selected areas in Michigan. The range of professionals interviewed was broader than in previous surveys including clergy, morticians and coroners, for example. In this study, four major categories of abuse were used. The first, passive neglect, was defined as being ignored, left alone, isolated, or forgotten; the second, active neglect, was described as having necessary things withheld such as companionship, medicine, food, exercise, or assistance in toileting. Verbal or emotional abuse, the third category, included being called names, treated as a child, frightened, humiliated, intimidated, or threatened. Physical abuse, the fourth type, meant being hit bruised, molested, etc. In order of frequency of reporting from the respondents, passive neglect was found to occur more often than active; verbal emotional abuse was next, followed by active neglect and finally physical abuse. While many of the respondents cited little or no direct experience with physical or verbal abuse or active neglect, over half of them were familiar with cases of passive neglect.

The authors also noted that different professional groups reported experiences with different types of abuse, perhaps due to the particular settings, training and perspectives which they represent. They recommended that adequate and acceptable forms of assistance be made available to families living in stressful or potentially explosive situations.

House Select Committee on Aging Investigation

As concern and indignation about the problem of elder abuse mounted in the Nation, the House Select Committee on Aging initiated a series of public hearings in 1979-80 and a year-long full scale national investigation. Their reports issued in Elder Abuse (A Hidden Problem) (U.S. House of Representatives, 1981) included a discussion on the nature and extent of abuse, a survey of action by state and federal governmental units, and suggested policy alternatives at the federal, state and local levels.

Abuse, for these investigators, was subdivided into physical injury, negligence and sexual abuse; financial exploitation; psychological; violation of rights; and self abuse. Based on their investigation and review of governmental documents and research findings, they concluded that physical violence is the most common form of abuse (including negligence), followed by financial abuse, abrogation of basic constitutional rights, and psychological abuse, which occurs simultaneously with other forms. The victims were most likely to be very old, female, and dependent on others for care and protection.

The House document stated that while one out of three child abuse cases is reported, only one of six of adult abuse comes to the attention of the authorities. The Committee also concluded that 4 percent of the nation's elderly may be victims of some sort of abuse. Sons are more frequently perpetrators (21 percent), followed by daughters (17 percent). Alcoholism, drug addiction, marital problems, and long term financial difficulties are the primary causes of stress. The report ends with a series of suggested policy alternatives at the federal, state and local levels, including consideration of federal legislation which would provide for financial support for programs of prevention, identification, and treatment of cases of elder abuse, neglect and exploitation and establishment of a National Center for Elder Abuse whose task it would be to develop a model state elder abuse statute.

Sengstock and Liang Study

Since the initiation of the Model Projects, the results of another research project on elder abuse have been published. Focusing on the victims and their families, Mary C. Sengstock and Jersey Liang (1982) of Wayne State University in an Andrus Foundation supported project, "Identifying and Characterizing Elderly Abuse" provide further evidence about the characteristics of elder abuse, the difficulties in identification of cases, and the variability in the quality of services given to victims. This research team describes elder abuse as physical abuse (slaps, punches, etc.); physical neglect (the failure to provide necessities of life); psychological abuse (direct verbal assaults and threats); and psychological or emotional neglect (isolation or lack of attention).

Questionnaires were mailed to 302 Detroit area agencies dealing with the elderly. Approximately one-third (36 percent) responded, providing information on 77 cases. Further information was obtained by interviewing persons involved in 20 of the cases. The authors found that about one-third of the cases were 80 years or older and three-quarters (74 percent) were female. Physical and emotional impairments were found in about 22 percent of the cases. Eighty percent had incomes of $10,000 or less. Almost half (49 percent) of the abusers were children of the victim, with sons accounting for 26 percent and daughters 23 percent. About one in eight were spouses. Among the cases in the sample, the most often cited type of abuse was psychological, occurring more than four-fifths (82 percent); financial was found in more than half (55 percent) and physical in 43 percent. Psychological abuse accompanied other types of abuse. In discussing the various intervention strategies the authors state that effectiveness of services seems to be highly dependent on the characteristics of the agency and the worker.

Gioglio Study

Conducted under the auspices of the New Jersey Division of Youth and Family Services and the Division of Aging, this study, "Elder Abuse in New Jersey (Gioglio, 1983), drew a random probability sample of the state's elderly population to determine the extent of elder abuse. A structured questionnaire which included four vignettes featuring four different types of abuse [physical (hitting), psychological (verbal cruelty), neglect (withholding food and medication) and financial abuse (misuse of funds)] was administered to 342 New Jersey residents 65 years of age to learn whether in the previous year, they had known of similar situations. A total of 23 unduplicated incidents of various forms of abuse were cited by 16 of the respondents. Five said that they themselves had been abused. Eleven reported knowledge of a total of 18 other older persons who had been so mistreated. Among the group, misuse of finances or property was the most prevalent form.

It is the author's view that the approximately 1 percent rate, figured on the basis of the 5 reports of abuse/neglect, understates the actual extent of victimization of New Jersey's elderly. Because it was not possible to establish what proportion the other 18 cases represented, this statistic could not be generalized to the entire population. Also, the small numbers prevented further analysis of the data for causal factors. However, the author did recommend a number of specific preventive and corrective actions: to provide more legal options and resources for the Protective Services Departments handling abuse cases; to establish training programs for family members caring for elderly relatives; and to concentrate future research efforts on the socioeconomic and personal causes which surround the mistreatment of the elderly.

Giordano and Giordano Study

This study, "Individual and Family Correlates of Elder Abuse (Giordano and Giordano, 1983) is based on 600 cases of abused and 150 cases of non-abused elders taken from the files of the Aging and Adult Services Units in 5 Florida counties. The purpose was to examine various individual and familial circumstances related to four types of abuse: physical (bodily harm), neglect (breach of duty, violation of rights), psychological (fear, anxiety, or isolation), and financial exploitation (theft or conversion of money or material possessions). Using multivariate analysis, the investigators showed that different characteristics were related to the different types of abuse. The physically abused person was apt to be physically ill, sustain a number of abuses, and live with the perpetrator while the neglected elder was likely to be intellectually and physically impaired. The number of abuses and the adult child-parent conflict were factors associated with psychological abuse; financial problems, income, age and living with abuser were identified with financial exploitation. In a discriminant analysis of the two groups of clients, intellectual impairment, living situation and marital problems were better descriptors of the abused than the non-abused elders. When the results were cross validated, the researchers found that the predictors were not totally replicated, a situation which they attribute in part to the complexity of the patterns of behavior being examined and characteristics of abuse in particular. The most important finding according to the authors was the emergence of spouse abuse as a dominant variable in physical, psychological and multiple abuse cases. They concluded their study by stressing the importance of standardizing definitions, case recording and reporting so that more accurate information will be available.

B. Comparison of Earlier Studies

As this cursory review demonstrates, research in the area of elder abuse and neglect is not well-developed. It does, however, provide some preliminary and tentative information about this complex phenomenon. It is fair to say that none of these studies has established the extent of elderly abuse/neglect, or even arrived at a plausible estimate although two of the eight state that this is one of their aims. The first of these, Block and Sinnott (1979), calculate a proportion based on the fact that 4 percent of their respondents reported cases (26) of elder abuse or neglect. They extrapolate this figure to the total U.S. population and arrive at a total of nearly one million cases nationwide. As Callahan (1981) has pointed out, this estimate is worthless, due to the way cases were identified (through surveys of agencies and professionals) and to the small size of the sample. Callahan correctly asserts: "No national projections can be made from 26 cases."

The second attempt is by Gioglio (1983). His estimate that 1 percent of New Jersey's elderly based on 5 cases out of a sample of 342 suffer from some type of abuse/neglect is also questionnable, as he himself acknowledges. With such a small positive finding, the confidence interval could probably range from zero cases at the lower limit to a much higher percentage of cases at the upper limit. Similarly, the statement as reported by the House Select Committee on Aging (1983) that only one out of six cases of elder abuse comes to the attention of authorities is suspect, as well. All that can be inferred, then, from these studies is the simple fact that elder abuse and neglect exists. Many service agencies and professionals are able to identify cases, and interviews have been carried out with the elderly who admit that they have been abused/neglected or know of persons who have. The precise extent of the problem, however, remains unknown.

Although the various studies have employed quite different methodologies, they have produced a fairly consistent profile of the abuse/neglected population. The victim is more likely to be female and very old. Block and Sinnott reported that the mean age of their cases was 84 years. O'Malley, et al. found that 55 percent of the abused/neglected were 75 years or older and Gioglio, 57 percent. The level of disability of these victims is less clear. While most studies report that these individuals tend to suffer from physical and mental impairments, the degree reported by the researchers ranges from 22 percent (Sengstock and Liang) to more than 75 percent (O'Malley, et al).

There is also some discrepancy in the description of the perpetrator, reported by Block and Sinnott to be predominantly female, but male by the other investigators. Giordano and Giordano analyzed their cases by type of abuse and found that abusers were more apt to be male if physical, psychological and financial abuse was present, but female in cases of neglect. The data concerning the relationship of the abuser to abused is fairly consistent for the studies which show that adult children are involved in slightly less than half the situations and spouses from about one-eighth to one quarter.

These findings incomplete as they are, are unfortunately the only ones that emerge reliably from the studies. Results relating to the frequency with which abuse/neglect occurs and the types of abuse/neglect most often found are virtually impossible to compare due to widely varying ways of defining the problem. Furthermore, none of the studies presents reliable evidence on the causes of abuse/neglect. In the next section, these and other weaknesses in the studies will be discussed.

C. Critique of Earlier Studies

The first major difficulty in applying results from previous research on elderly abuse and neglect to the development of this study was the lack of uniformity in the definition of "abuse and "neglect." No universally accepted meaning of "elder abuse" exists. For instance, Lau and Kosberg (1979) included four categories in their study: physical abuse, psychological abuse, material abuse, and violation of rights. Block and Sinnott (1979) include the first three categories, omit "violation of rights," and add "poor residential environment." The overlap is deceptive, however, as Lau and Kosberg divided physical abuse into the following sub-types: direct beatings, lack of personal care, lack of food, lack of medical care and lack of supervision. Block and Sinnott include bruises and welts, sprains and dislocations, malnutrition and freezing, and abrasions, lacerations, cuts and punctures. Thus respondents were asked for quite different characteristics under the same heading. Additional examples could be given, but let these suffice, as many others have commented on definitional inconsistencies among the studies (Callahan, 1981; Pedrick-Cornell and Gelles, 1981; Douglas and Hickey, 1983).

A second weakness with the earlier studies can be traced to the criteria used in each study to determine the population at risk of abuse, on whom data were collected. Some researchers (Douglass, et al., 1980) have included persons under 60 years of age in their sample, while most others have restricted their research to persons 60 years, or 65 years and over. Block and Sinnott limited their study to persons sharing a residence with others, whereas O'Malley et al., Gioglia, and Giordano and Giordano included all abused or neglected elders in non-institutional settings.

Thirdly, the studies have employed widely different methods: indepth view of cases selected from the client population of social service agencies (Lau and Kosberg, 1979); mail survey (Douglass, et al. 1980, O'Malley, et al., 1979 and Block and Sinnott, 1979); interviews with professionals (House Select Committee on Aging, 1981); abstracts of mandatory reporting data (Giordano and Giordano, 1983) and random sample survey (Gioglio, 1983). This methodological inconsistency makes it particularly difficult to compare the research results.

A fourth drawback of the studies is that, except for the Sengstock and Liang and Gioglio work, they rely on professional reports of cases either through survey data or abstracted case material from agency files. A professional may interpret the circumstances of a case in a very different way from that of the actual individual involved, or from practitioners in other disciplines. The O'Malley, et al. study included a higher proportion of home care staff, the Douglass et al., social workers, and the Sengstock and Liang, legal servies personnel. Those studies which interviewed elderly directly were limited to the victim (Sengstock) in 20 of the 77 cases or included the entire sample of the general population (Gioglio).

Fifthly, only one of the studies described above has included a non-abused comparison group of elders (Giordano and Giordano), but the analysis was based on only a few variables. Without control groups, it is impossible to kn ow if the generalizations which have been made such as abused/ neglected elderly tend to be physically and/or mentally impaired, are valid. Finally, the studies do not give much attention to treatment strategies. Except for the O'Malley, et al. survey, which asked the respondents for information about the action taken, none of the reports furnish information beyond characterization of the abused, abuser, and the abuse circumstances, although they all include suggestions on intervention, prevention and treatment.

For these reasons, knowledge about elder abuse and neglect is still in its "infancy stage." The existence of elder abuse has been verified, and some tentative descriptive findings produced. Although the etiology of elder abuse and the specific dynamics of abuse situations are still unknown, several theoretical explanations have been proposed. They are discussed in the section below.

D. Theories of Elder Abuse

After reviewing the early works described above, Villomare and Bergman (1981) in their manual, Elder Abuse: A Guide for Practitioners and Policy Makers offer the following list of major causes of elder abuse: impairment which leads to dependency and perhaps to a learned helplessness response in the elder; individual pathologies; internal family dynamics including failure to resolve a filial crisis and increased stress in caring for a disabled family member; external stress, such as income and employment problems; and negative attitudes toward the elderly and the disabled. A second set of explanations for elder abuse, which also draws on the results of those early studies, is found in the House Select Committee on Aging report (1981). It includes retaliation, aggression and violence as a way of life in America; lack of close family ties; lack of financial resources; resentment of dependency; increased life expectancy; lack of community resources; stress and other life crises, such as unemployment and environmental conditions; and history of personal and mental problems, such as alcoholism and drug abuse. Still, a third summary, given by O'Malley, et al. (1983) in their article in the Annals of Internal Medicine, categorizes the theoretical work from the early studies as follows: physical and mental impairment of the patient (the physical dependent elderly person); the effect of external stresses on the abuser (the stressed caretaker); learned behavior (the violent family) and the individual problems of the abuser (the pathological abuser).

It is evident from all lists that elder abuse is viewed as a multifaceted problem which can be traced to a number of causes: societal, familial, interpersonal or individual in origin. In searching for a theoretical basis for elder abuse, most researchers have turned to the literature on family violence. However, the simple extension of concepts relating to other forms of family violence to elder abuse and neglect may be misleading. While it is useful to consult the family violence literature, it should be done only with the knowledge that the elderly occupy a special status in our society. Any attempt to understand the dynamics of abuse situations must take into account theory and research relating specifically to the aged. Several questions must be asked: What is it that makes the elderly vulnerable to abuse? How does being old specifically pattern family violence? In reviewing the sociological and psychological literature on spouse and child abuse and the gerontological literature on the family relations of the elderly, several areas have emerged as possible explanation of elder abuse and will be discussed in turn.

- Intraindividual dynamics (psychopathology of the abuser)
- Intergenerational transmission of violent behavior ("cycle of violence")
- Dependency and exchange relations between abuser and abused

- External stress
- Social Isolation

Intraindividual Dynamics

Intraindividual theories blame abuse on some (usually pathological) characteristic of the abuser. As Gelles (1974) has noted, many studies of child abuse have relied on the idea "that the parent who abuses his or her child suffers from some psychological disease which must be cured in order to prevent future abuse". This research has been primarily carried out by psychiatrists, social workers, and other clinicians. Some of these writers attribute abuse to sadistic personality traits. Young (1974) for example, writes that "the outline of abuse" is "the perverse fascination with punishment as an entity in itself" (p.189). Others trace it to a flaw in the socialization process, and tend to downplay social structural factors as important determinants of child abuse.

A number of investigators have also traced wife-battering to psychopathological traits in the perpetrator. Shainess (1975) catalogues a variety of "personality problems" in the wife-batterer that lead to abuse. Men who have connected feelings of pleasure with being beaten, for example, will have violent feelings fused with erotic ones. Further, "passive-aggressive" men and "obsessive-compulsive" men alike may beat their wives for reasons due to their psychological make-up. In this vein, Faulk (1974) studied 23 men who had been jailed for assaults on wives or cohabitants. He classified these individuals into various pathological types, such as "violent and "bullying", "dominating," and "dependent and suspicious." Lion (1977) used a similar approach, although he highlights the husband's "need for superiority, which shields massive insecurity" (p. 127).

Gelles (1974) severely criticizes such intraindividual explanations of abuse. He argues that little agreement exists between various writers as to which pathological traits characterize abusers. Further, these studies do not rigorously test hypotheses, but instead offer post-facto explanations for deviant behavior. A final weakness is reliance on clinical samples, without the use of non-abuse comparison groups. Gelles (1974) goes on to argue for a sociological approach to child abuse, one that looks at independent variables such as socioeconomic class, economic stress, and unemployment. Straus (1979) gives a more complete version of this argument, and applies it family violence in general. In recent years, strictly intraindividual theories have been increasingly avoided by researchers.

A variant of this type of theory has gained some acceptance, however, at least as a partial explanation of why abuse occurs. This is the relationship between alcohol and drug abuse and family violence. Numerous studies have in fact found support for such a relationship (cf. Coleman and Straus, 1981; Sedge, 1979). While it is not clear precisely how substance abuse is related to violence, the two behaviors have been reported so frequently in common that this cannot be ignored as a contributing factor in abuse. Whether alcohol and drug consumption act to diminish inhibitions against violence, or to allow for "deviance disavowal," they appear to pave the way for abuse in some circumstances.

But what about other forms of supposed psychological disturbance? In light of the above discussion, ought some measure of mental illness, independent of the fact that abuse has occurred, be included in the proposed project? Interestingly, the psychopathological model has been largely shunned by elder abuse researchers. Douglass, et al. (1980) do include the "flawed development" of the abuser as one cause of abuse, which results from problems in the childhood of the abuser. Lau and Kosberg (1979) also refer to the problem of the "non-normal" child (e.g., mentally ill or retarded, or alcoholic) who has been cared for by parents all his or her life. If the parents become impaired, they may be placed in the hands of a person unable to manage his or her own life, let alone those of dependent elderly relatives. Beyond these two examples, researchers have focused on intrafamilial and sociocultural cases of abuse. Inspite of this somewhat negative view regarding the psychopathology of the abuser as a cause of abuse, it is worthy of further study.

There is a more theoretical argument in favor of at least considering the role of psychopathology in elder abuse. A major difference exists in the degree of normative prohitition against various types of family violence. Straus, et al. (1980) found a great deal of popular approval for physically punishing children, and even a surprisingly high approval rate for spousal violence. However, it can be convincingly argued that it is a much more deviant act to strike an impaired, dependent elderly person. There is no normal pattern for being violent towards one's elderly relatives; it is therefore a stronger normative violation than either child or spouse abuse. Therefore, one might expect a greater degree of psychopathology on the part of elder abusers: they must engage in a more deviant behavior than others. In summary, although researchers in child and spouse abuse are now less prone to attribute family violence to the psychological state of the abuser, it appears that persons who abuse elders may be more severely disturbed than others.

Intergenerational Transmission of Violent Behavior

This explanation for abuse is grounded in social learning theory, and holds that the child learns to be violent in the family setting. Abuse in this model results from the fact that a violent parent has been taken as a role model. When frustrated or angry as an adult, the individual relies on this learned behavior, and lashes out violently. The notion based on this approach of a "cycle of violence" has become almost a commonplace: it is widely held that abused children, for example, grow up to become child abusers.

Gelles and Straus (1979b) conducted an extensive review of the literature on this subject. They report that the frequency with which this "cycle" has been found gives credence to the assertion that people learn to be violent by experiencing and witnessing violence in their own household while growing up. In many cases, they claim, "there appears to be an almost undiluted 'transfer,' with violence learned as a child practiced as an adult" (p. 29). This finding is upheld by Straus, *et al*.'s (1980) national survey. That study revealed that a greater degree of physical punishment at the hands of either parent was positively associated with a higher rate of abusive violence towards that person's own children. Children who observed their fathers striking their mothers also had a higher rate of violence towards their children. This fits in well with Owens and Straus's (1975) study, which found that exposure to violence as a child was correlated with a general approval of violence as an adult.

No evidence exists at present as to whether elder abusers have experienced violent upbringings. Such a connection would indeed seem likely, based on the strength of this finding in other forms of abuse. It is important to note, however, that a difference exists between elder abuse and child and spouse abuse regarding the transmission of violent behavior. Obviously, children who abuse elderly parents were not *themselves* abused as elderly parents; the cycle of violence must therefore take a different form. Rather than becoming an abuser because one was abused by someone else, the cycle becomes much more direct: the formerly abused child strikes out at his or her *own abuser*. This involves a different psychological process: one with elements of retaliation as well as imitation. In light of the above discussion, a history of family violence seems a likely predictor of abuse of the elderly.

Dependency and Exchange Relations

Exchange theory, popularized by such thinkers as Homans (1961) and Blau (1964) has come to be fairly widely used by both family violence researchers and social gerontologists. Thus, noted family scholars such as Goode (1971) and Nye (1979) have applied exchange principles to domestic abuse of wives and children. Sussman (1976), Cicirelli (1981), and Dowd (1975) among others have looked at the changing status of the elderly using the exchange paradigm. While exchange theory has not been specifically applied to elder abuse, some exchange propositions appear to be applicable to that problem.

Put very simply, exchange theory holds that humans attempt in relationships with others to maximize their rewards and minimize their costs. In addition to this principle, it holds that the provision of a reward to someone else obligates that person to the former. Theoretically, when reciprocity is no longer achieved, the relationship will end. However, as Gelles (1983) has argued, families provide special instances of exchange in which it may not be feasible to end interaction, even when reciprocity is absent. In such a situation, he argues, abuse can occur. Homans (1961) has referred to a "principle of distributive justice," by which people expect to be appropriately rewarded for their activity. When this principle is violated, there could be "increased anger, resentment, conflict, and violence" (Gelles, 1983, p. 280).

How might such a perspective further relate to family violence? Goode (1971) in his seminal article on the use of force and violence within the family views family structure as a continuous flow of transactions, or "exchanges". Conflict results in the family when people feel cheated in the exchange process. Agreement as to the value of what each gives is key to a relatively harmonious family life. He asserts, like Gelles, that escape is less easy from the family than it is in other situations when exchange is going poorly. People feel irrational ties to their families which keep them involved in spite of painful interactions. This can lead to a "pressure-cooker" situation in which violence occurs. It is worth quoting Goode at length on this issue:

> "...exchanges are made between family members on the basis of the evaluation each brings to or accepts within the family, so that in a harmonious domestic unit each feels the exchanges are more or less equal in value...as long as each values what he gets equal to what he gives, all are fairly content...When, however, one or more family members begins to feel a continuing imbalance, they start to engage in conflict about them...such conflicts can escalate to the point of violence because no simpler or easier resolution emerges" (1971, p. 42)

This is not unlike Nye's (1979) formulation of the problem. He notes that abusive husbands will suffer costs from their wives as a result of violent behavior (e.g., loss of affection). However, if the husband already feels his wife is providing few rewards, he will not feel he has much to lose by using physical strength to get his way. On the other hand, a husband who perceives his wife as providing many rewards will anticipate losing much by battering her. This leads Nye to a hypothesis: The greater the rewards a husband sees himself receiving from his wife, the less likely he will be to use physical force against her.

The above is only one reading of exchange theory; another is presented below which leads to quite different conclusions. Based on this version, however, an explanation for elder abuse can be developed: that the increased dependency of an older person on a caretaker creates an unbalanced exchange, and that this results in violence against the elder. In fact, the belief that the dependency of elderly individuals is a major cause of abuse is probably the most widely held in the literature. This view has developed in large part from recent gerontological research on the strains of family caregiving to elderly relatives.

Dependency here is defined as requiring the assistance from another person or persons to continue living in the community. This assistance could take the form of aid in performing basic activities of daily living (dressing, bathing, cooking, shopping, etc.); financial support; or emotional support and companionship. Many gerontological researchers have commented upon the stress that results from providing such assistance to impaired elderly relatives. Zarit, et. al. (1980) found that caretakers of elderly persons with senile dementia experienced many problems; excessive dependency on the caregiver was a major burden for family members. Archbold (1982) showed that costs to caregivers included decreased freedom, lack of privacy, constant irritation, guilt, career interruptions, and financial burdens. Perhaps for reasons such as these, Fengler and Goodrich (1979) discovered that wives of elderly disabled men reported much lower life satisfaction than did a national sample of the elderly.

Related studies have focused specifically on the psychological and emotional aspects of caregiving. Horowitz and Schindelman (1980) found that caretakers of dependent elderly experienced increased fears about their own aging. Perhaps the most complete catalogue of the negative emotional impact of caregiving appears in a popular work by Silverstone and Hyman (1976). These authors claim that fear, anxiety, anger, hostility, and shame can strike children caring for their elderly parents.

In addition, research on services to caregivers highlights the strains of care. Safford (1980) noted a great need for programs to assist families of the mentally impaired elderly. These families suffered from a "sense of anguish as they helplessly saw the physical and mental deterioration of their kin" (658). Crossman, et al. (1981) see supportive services as alleviating the "anger and frustration" of wives caring for disabled husbands, while Hausman (1979) emphasizes the unpreparedness of children for the dependency of their elderly parents.

Based on findings such as these, a number of researchers have assumed that the growing dependency of an elderly person increases the likelihood of abuse. Davidson, for example, ties abuse directly to the "crises" created by the needs of an elderly parent for care. She writes:

> Yet just as the child is abused by his parent who resents the dependency of the child because the parent himself lacks satisfaction of needs, the adult child who must assume a caretaker role to his own parents may become abusive as a result of his parents' dependency and the lack of need satisfaction (p. 49).

Steinmetz has been perhaps the major proponent of this view, arguing that families undergo "generational inversion", in which the elderly person becomes dependent upon his or her children for financial, emotional, physical, and/or emotional support. This leads to severe stress on the part of the caregiver. Steinmetz asserts: "As the economic, physical, social, and emotional dependency needs of the vulnerable elderly increase, the potential for abuse increases unless adequate resources are available" (1983). This hypothetical relationship between dependency and abuse fits quite well into the exchange paradigm. As the costs of the relationship grow to the caregiver, and the rewards diminish, the exchange becomes perceived as unfair. If the caretaker feels unable to escape the situation, he or she could then become abusive.

However, this form of dependency does not exhaust the exchange paradigm as it might apply to elder abuse; in fact, elder abuse situations appear to be too complex for a monocausal explanation such as this. In particular, research has shown that many elderly are quite dependent on their relatives (cf. Kulys and Tobin, 1980). The question therefore arises: Why are some of these dependent elderly abused and others not? In light of the fact that abuse occurs in only a small proportion of families, no direct correlation between dependency of an old person and abuse can be assumed.

Dowd (1975) in his attempt to apply exchange theory to aging, asserts that "intrinsic to the concept of exchange is the notion of power." He continues: "the partner in a social exchange who is less dependent on that exchange for the gratifications he seeks enjoys a power advantage" (p. 587). This advantage can be employed to make the exchange partner comply with one's wishes. If this observation is added to Goode's (1971) point that people do not choose to use overt force when they have other resources at their disposal, then the hypothesis that the dependency of elder breeds abuse can be called into question. Why, if someone already holds much power over another, would he or she resort to force? If the abused is severely dependent, then the abuser would have a wealth of resources to force that person to comply: violence would not be necessary.

A different explanation based on the family violence literature helps resolve this issue. Finkelhor (1983), in his thoughtful attempt to identify common features of family abuse, notes that abuse can occur as a response to perceived powerlessness. Acts of abuse, he notes, "seem to be acts carried out by abusers to compensate for their perceived lack or loss of power" (p. 19). Thus, spouse abuse has been found to be related to a sense of powerlessness, and the physical abuse of children "tends to start with a feeling of parental impotence" (p. 19). It may be that the feeling of powerlessness experienced by an adult child who is still dependent on an elderly parent is especially acute, because it goes so strongly against society's expectations for normal adult behavior. This perceived power deficit appears to have more explanatory power than the notion that the abuser holds much power in the relationship.

Thus, one reason why some persons abuse elderly relatives may be to achieve a specific result, such as obtaining money. Alternatively, the reason may be based in exchange processes: the individual perceives a power deficit, and seeks to restore power (Finkelhor, 1983, p. 19). Having few resources with which to do so, the person then resorts to violence. Both of these explanations deserve further exploration.

In summary, viewing the results from family violence and gerontological research in light of exchange theory principles leads to the conclusion that dependency may play a critical role in elder abuse. However, it has been argued that it is not yet known who is depending on whom in these abusive relationships. Does an elderly person come to make excessive demands on caregivers? Are the abusers persons who have remained dependent on the abused into later life, and have unrealistic expectations of what the latter can provide? Or does some combination of these two factors lead to abuse?

External Stress

In the past decade, sociologists in a number of areas have increasingly come to focus on stress; family sociology is no exception. As Straus (1979b) has asserted, the nuclear family constantly experiences major changes as a result of the family life cycle: the birth of children, the aging and deterioration of members, retirement, and death, among others. Further, he notes that stress interferes with what families are expected to do: provide food, clothing, and shelter, for example, and raise healthy, well-adjusted children. Society does not always bestow upon families the resources to do these things. If Mechanic's (1978) definition of stress is used, the "discrepancy between the demands impinging on a person and the individual's potential or actual responses to these demands" (p. 292), stress would appear to be endemic to most families. In addition to long-term sources of stress, life-change events such as those measured by the well-known Holmes and Rahe (1967) scale can also be extremely stressful, and have been found to be related to a variety of health problems.

It is therefore no surprise that investigators have found a positive relationship between external stress (as differentiated between the stress that results from interpersonal relationships in the family) and abuse. Gil (1971) was one of the first researchers to cite such stressors as poverty and unemployment as causes of child abuse. These findings have been substantiated by Justice and Justice (1976) who reported that child abusing families in their study were subject to high levels of stress. Many of the families they interviewed had undergone a long series of stressful events: accidents, illnesses, financial mishaps, and so on.

Straus, *et al*.'s (1980) findings draw this connection most clearly. They examined the relationship between stress and child abuse in a nationally representative sample of 1,146 parents. A modified version of the Holmes and Rahe scale was used. The authors report that parents who had experienced none of the 18 stressors on the scale had the lowest rate of child abuse. As the number of stressors increased, the child abuse rate grew as well. Other researchers have found stress factors such as "unemployment, economic problems, unwanted children, and illness" (Sedge, 1979, p. 54) to be related to spouse abuse.

Only one study of elder abuse has made a systematic attempt to examine stress as a cause of elder abuse. Sengstock, Barrett, and Graham (1982) report that 85 percent of the 20 abused elderly they interviewed had experienced five or more stressful events, and 20 percent had experienced 19 or more. While this seems quite high, no comparison is made with a non-abused group of elderly. A further problem is that they measured stress on the victim; evidence from previous studies indicates that stress on the *abuser* is the key determinant.

Thus, a stress perspective on abuse can be seen as an alternative to the theories previously discussed. In Gelles and Straus's (1979a) terms, it is a "socio-cultural" theory, rather than a social-psychological or intraindividual one, in that it emphasizes social structural, macrolevel variables like unemployment or economic conditions. However, as Sengstock and Liang (1982) have argued, the social stress model alone cannot explain elder abuse, as it does not account for why some families respond to stress with abuse and others do not.

Social Isolation

The social isolation of a family has been proposed as a cause of abuse for two reasons. First, there is a vast body of literature which supports the thesis that social support acts as a moderator of life stress and facilitates coping with crises (for reviews of this literature, see Cobb, 1976; and Wan, 1982). For example, researchers have found that social support has a positive impact on health status and health behavior. At least one gerontological research group (Zarit, et al., 1980) found that active support from kin reduced feelings of burden on the part of caregivers to the elderly. Thus, it will be important to examine the way in which social support resources affect the ability of families in the proposed study to cope with stress.

Secondly, social isolation has been found to be characteristic of families in which child and spouse abuse occurs. Hennessey (1979), reports from her comprehensive review of the literature that child abusers tend to be social isolates. Gil (1971), for example, found that about half the parents in his study had lived one year or less in the home in which the abuse occurred. This is an indication of lack of ties to the surrounding community. Justice and Justice (1976) also note that abusive parents in their study tended to be "loners". Gelles (1972) reports similar findings for spouse abusers.

Nye (1979) provides a reasonable explanation for this aspect of abusive families. Violence that is considered to be illegitimate tends to be hidden. Detection of such violence can result in informal sanctions from friends, kin, and neighbors, and formal sanctions from police and the court. Thus, he hypothesizes that child and spouse abuse will be "less frequent in families that have relatives and/or friends living nearby" (p. 36). The presence of an active social support network may thus have a deferring effect on elder abuse as well, for that is a highly illegitimate behavior.

As the literature indicates, no single theoretical paradigm exists to explain elder abuse. Instead, there is an array of competing explanations for the problem. In fact, the theories that have been discussed are by no means the only ones that could be included in the review. Based on existing research however they appear to be the most persuasive. Both the findings of the early studies and the proposed theoretical explanations have guided the development of this evaluative research plan. More specific references to their contribution will be found in the subsequent chapters which describe the methodology and results of the various tasks.

CHAPTER THREE

DESCRIPTION OF THE PROBLEM

With the findings from previous research on elder abuse and neglect and the proposed causal factors as a framework, a series of hypotheses was developed about the victim, perpetrator and abuse/neglect situation. These in turn served as guidelines for the design of instruments for the assessment of cases seen by the three Model Projects and a comparison group of non-abuse/neglect clients. The methodology and results from the case assessments are presented in the first section of this Chapter. The next section analyzes the differences between a sub-set of the abuse/neglect cases and non-abuse/neglect cases and the third section compares the case loads of the three Projects.

I. Case Assessments

A. Methodology

It is important to realize that the evaluation activities which are described in the following pages were initially designed for program planning and development purposes. The original goal of the evaluation as it appeared in the proposal to the Administration on Aging was to provide information which would assist the Massachusetts Department of Elder Affairs in developing a statewide plan for the delivery of comprehensive protective services for abused and neglected elders. A methodology was selected which would be the least disruptive to the Model Projects (two sites at the time, Worcester and Boston); which would make use of forms already part of the day-to-day operation of the agencies; and which would involve project personnel in decision making. Even though these circumstances did not allow for a sophisticated research design, they did provide an opportunity to study the problem of elder abuse and neglect in a manner that had not been done before.

As noted earlier (Chapter One), the study was based on six research questions, which were later re-drafted into three evaluation objectives. The first of the six questions is addressed in this chapter: What are the nature and extent of elder abuse in the geographic area? After a review of the literature in 1980, a series of statements was written into the application to AOA which were to serve as working hypotheses for the study; some are descriptive and some are causal in nature:

- The abused/neglected elder is likely to be in a situation of dependency towards the perpetrator, whether economic, physical, or psychological.

- Both the physically and mentally healthy, as well as the frail and impaired elderly are the victims of abuse/neglect.

- The abuser in the past may have been a victim of abuse/neglect.
- The perpetrators, are most frequently relatives of the abused; and among relatives, adult children are the largest group of abusers.
- The perpetrators are most frequently the primary care givers.
- Abuse neglect may result from physical, mental, social or economic stress caused to the perpetrators by the necessity of caring for the abused.
- Psychological and non-physical forms of abuse/neglect are more prevalent then physical abuse.
- Abuse/neglect often associated with finances
- Abuse/neglect tends to be recurring.

A more extensive review of the family violence literature shortly after the project became operational suggested two more areas for investigation:

- Psychopathology of the abuser may play a role in elder abuse/ neglect.
- Abuse may occur in families that are socially isolated.

It is the five causative factors (psychopathology, dependency, cycle of violence, stress, and isolation described previously and repeated above) that constitute the framework for the methodology and results that follow.

Definitions

In order to accommodate the definitions of elder abuse and neglect which appeared in each of the Model Project's application for funding as well as those that had been used in previous research, a five category definition was adopted: physical, psychological, and material abuse and active and passive neglect. See Figure 1. For the purpose of this study, "nature of abuse" was defined by these five categories and "extent of abuse" by both severity and prevalence. Severity was measured by the specific manifestations of abuse and by regularity of occurrence. Since it was not possible within the scope of the Model Projects to include a sampling of the general population, prevalence was interpreted to be the proportion of the case loads of the reporting agencies in the community survey which involved elder abuse/neglect

Figure 1. Definitions of Abuse and Neglect

ABUSE:

Physical Abuse:	the infliction of physical pain or injury, physical coercion (confinement against one's will) e.g., slapper bruised, sexually molested, cut burned, physically restrained, etc.
Physiological Abuse:	the infliction of mental anguish, e.g., called names, treated as a child, frightened, humiliated, intimidated, threatened, isolated, etc.
Material Abuse:	the illegal or improper exploitation and/or use of funds or other resources

NEGLECT:

Active Neglect:	refusal or failure to fulfill a caretaking obligation, INCLUDING a conscious and intentional attempt to inflict physical or emotional stress on the elder; e.g., deliberate abandonment or deliberate denial of food or health-related services
Passive Neglect:	refusal or failure to fulfill a caretaking obligation, EXCLUDING a conscious and intentinal attempt to inflict physical or emotional distress on the elder; e.g., abandonment, non-provision of food, or health-related services because of inadequate knowledge, laziness, infirmity or disrupting the value of prescribed services.

situations. As noted in the report of the survey, the attempt to calculate a rate of elder abuse/neglect for each reporting agency was unsuccessful. (Appendix II, Exhibit 1, pg. 42)

Data Collection

The Case Assessment form (Appendix I, Exhibit 1) used to collect data was designed with the assistance and advice of the Worcester Model Project staff, and later reviewed and approved by the Syracuse and Rhode Island project personnel. It incorporated a portion of the Home Care Client Assessment Form (CNAP), the standard assessment form in use by all home care corporations in Massachusetts and many aspects of the Individual Case Report (See Appendix II, Exhibit 1) which had been used in the first elder abuse survey of community agencies. That questionnaire was based on information from the early research studies on elder abuse and neglect, had been pre-tested with 14 agencies and then used to collect data on 127 cases. The CNAP tool included the key facts on the victim, assessment of physical health, nutritional need, and social supports. By utilizing the Massachusetts home care form, the intent was to simplify the work of the Worcester Project personnel in collecting information and to make it possible to compare the elder abuse victim with non-abused/neglected cases seen by the home care agency. Actually, the CNAP tool had only been in use a relatively short time and its limitations not fully recognized at that point. Only after the Projects had been underway was there a realization that certain parts of the DEA form were ambiguous, and that the section on functional status focused not on the status of the client but on the needs for services. In retrospect, other instruments should have been used to collect function data.

The Individual Case Report had included items on the abuse situation, the manifestations of abuse and neglect, the perpetrator, the elderly client, the action taken and barriers to services. Several of the questions, when adapted for the Case Assessment permitted the worker to make judgments about the degree, as well as presence or absence of selected attributes. The purpose of the case assessment (at intake) was to provide a picture of the abuse/neglect situation at the time when the case became known to the agency, although in some instances it took several weeks to gather the necessary information.

It must be kept in mind that the responses on the Case Assessments represent the perceptions and interpretation of the Project staff who filled them out. Training in how to use the form took place at several meetings of the Project Directors and staff. Also, assessments were only handled by 2 caseworkers at each site to insure reliability of the data. The Evaluation Team also monitored the forms as they were returned to make sure that the questions were interpreted in the correct way. However, in spite of the attempts to standardize the use of the form, the pattern of responses varied, due to the different types and approaches of the agencies, worker backgrounds, and professional styles. In two of the three sites, the workers did add comment on most of the questions, sometimes in great detail. The forms were coded by a data clerk, and all values checked by one member of he evaluation team prior to computerization.

Sample

The sample for this part of the evaluation study included all cases of elder abuse and/or neglect seen by the Model Projects between July 1, 1981 and June 30, 1983 in which the victim was 59 years of age or older at intake and living in a domestic setting, and the perpetrator was a family member or informal care-giver. The total number was 328 cases: Worcester, 59; Syracuse, 135; and Rhode Island, 134.

B. Results

In the pages that follow, the frequency distributions for the variables from the Case Assessment forms completed by the three Model Projects at intake are described with accompanying tables, beginning with the characteristics of the victims and perpetrators and types of abuse and neglect. The situational factors, grouped according to the theoretical explanations suggested in the previous chapter, are presented next. The section ends with the descriptive statistics on the intervention strategies and barriers.

Characteristics of the Victim

At the time of reporting, about three out of five of the victims were 75 years or older in the Worcester (59.2 percent) and Syracuse (62.7 percent) case loads and one out of two in the Rhode Island group (49.5 percent) (Table 3.1). The average ages of the victims in the three sites were: 76.8 years, Worcester; 78.0 years, Syracuse; and 74.2 years, Rhode Island. Most of the victims were female: four out of five in Worcester (79.7 percent) and Rhode Island (79.9 percent) and five out of six in Syracuse (84.4 percent); and a large majority were white (Worcester, 94.9 percent; Syracuse, 88.1 percent and Rhode Island, 91.8 percent). Almost one-third of the cases involved elders who were married (Worcester 36.2 percent; Syracuse, 30.7 percent; and Rhode Island 30.4 percent); and living with spouse (37.5 percent, Worcester; 33.9 percent Syracuse; and 31.4 percent, Rhode Island). The abused/neglected elders resided with children in 39.3 percent of the Worcester cases, 34.8 percent of the Syracuse and 54.0 percent of the Rhode Island cases. A small proportion of each site case load was living with nonrelatives (Worcester, 10.7 percent; Syracuse, 16.0 percent, and Rhode Island, 10.7 percent).

Annual income for a majority of the victims in the Worcester project (61.1 percent) and the Rhode Island Project (74.4 percent) was under $5,000 a year; a somewhat smaller proportion of the Syracuse cases, (44.0 percent) of the case load was at this level. Even when the income of others in the household was included, about half of the sample reported totals under $10,000 a year (Worcester, 50.0 percent; Syracuse, 46.4 percent; and Rhode Island, 52.8 percent) (Table 3.2).

TABLE 3.1 AGE, SEX, RACE, AND MARITAL STATUS OF ABUSED/NEGLECTED ELDERS

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Age (mean years)	76.8	78.0	74.2
Under 60	1(1.7)	2(1.5)	3(2.3)
60-64 years	10(16.9)	13(9.7)	24(20.3)
65-69 years	7(11.9)	15(11.2)	23(17.3)
70-74 years	6(10.2)	20(14.9)	17(12.8)
75-79 years	11(18.6)	22(16.4)	22(16.5)
80-84 years	14(23.7)	26(19.4)	24(18.0)
85 years and older	7(16.9)	36(26.9)	20(15.0)
No answer	3	1	1
b) Sex			
Male	12(20.3)	21(15.6)	27(20.1)
Female	47(79.7)	118(84.4)	107(79.9)
c) Race			
Native Americans	1(1.7)	3(2.2)	2(1.5)
Black	-	11(8.1)	8(6.0)
Latino/Latina	2(3.4)	-	-
Asian	-	2(1.5)	1(0.8)
White	56(94.9)	119(88.1)	120(90.2)
Other	-	-	2(1.5)
No Answer	-	-	1
d) Marital Status			
Single	7(12.1)	8(6.0)	10(8.0)
Married	21(36.2)	41(30.8)	38(30.4)
Widowed	26(44.8)	72(54.1)	61(48.8)
Divorced/Separated	4(6.9)	12(9.0)	16(12.8)
No answer	1	2	9

TABLE 3.2 LIVING ARRANGEMENTS AND INCOME OF ABUSED/NEGLECTED ELDERS

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Household Composition			
Lives alone	8(13.6)	37(27.6)	31(23.3)
Lives with others	51(86.4)	97(72.4)	102(76.7)
No Answer		1	1
b) Relationship to others in household*:			
Spouse	21(37.5)	38(33.9)	38(31.4)
Children	22(39.3)	39(34.8)	66(54.5)
Siblings	5(12.5)	1(0.9)	10(8.3)
Other relatives	12(21.4)	26(23.2)	20(12.7)
Non-relatives	6(10.7)	18(16.1)	13(10.7)
No answer	9	41	26
c) Approximate annual income of abused/neglected elder:			
$ 4,999 or less	33(61.1)	48(44.0)	58(74.4)
5,000 to 9,999	18(33.3)	42(38.5)	17(21.8)
10,000 to 14,999	3(5.6)	16(14.7)	2(2.6)
15,000 to 19,999	-	1(0.9)	-
20,000 and over	-	2(1.8)	1(1.3)
No answer	5	26	56
d) Approximate annual income of household of abused/neglected elder:			
$ 4,999 or less	6(16.7)	3(4.3)	11(30.6)
5,000 to 9,999	18(50.0)	32(46.4)	19(52.8)
10,000 to 14,999	11(30.6)	25(36.2)	4(11.1)
15,000 to 19,999	1(2.8)	6(8.7)	1(2.8)
20,000 and over	-	3(4.3)	1(2.8)
No answer	23	66	98

*Column totals do not add up to 100 percent because of multiple responses to this question.

Characteristics of the Perpetrator

All Projects report a greater proportion of male perpetrators (Worcester, 66.1 percent; Syracuse, 58.6 percent; and Rhode Island 66.1 percent) than females, under 60 years of age than over (Worcester, 55.9 percent; Syracuse 51.9 percent and Rhode Island 70.6 percent), and white (Worcester, 96.6 percent; Syracuse 88. percent; and Rhode Island 88.2 percent) than non-white (Table 3.3). In the Worcester group, the abusers were more apt to be husbands (25.4 percent), than sons (23.7 percent), and daughters (18.6 percent). Among the Syracuse cases, the abusers included 23.7 percent sons, 20.0 percent husbands, and 18.8 percent daughters. The Rhode Island data indicated one-third of the abusers were sons (35.1 percent), almost one-fifth daughters (18.3 percent) and one-eighth, husbands (12.2 percent). Non-relatives were involved in 11.9 percent of the Worcester and Syracuse cases and 16.8 percent of the Rhode Island cases (Table 3.4). Generally, the victim and perpetrator lived in the same household (Worcester, 83.1 percent; Syracuse, 67.4 percent and Rhode Island, 76.9 percent) for a long time (average length of time: 25.6 years, 20.7 years, and 22.8 years respectively. In spite of this propinquity, the relationship between the victim and perpetrator was judged to be "poor" by the social workers in 77.2 percent of the Worcester cases, 71.0 percent of the Syracuse cases; and 79.0 percent of the Rhode Island cases.

Of particular interest in this study was the psychological status of the perpetrator since there is some controversy among elder abuse and family violence researchers as to the role of psychopathology as a causal factor. Included on the assessment form was a question pertaining to the perpetrator's explanation for the situation and the case worker's diagnosis. In over half the Worcester cases, the perpetrator (50.9 percent) denied that there was a problem. Among the Syracuse abusers, the major reason given were "overwhelmed by the abused's needs dependency", 35.7 percent and "denied" the problem, 27.8 percent. The most often cited reason by the Rhode Island abusers was "denial" of the problem (31.0 percent) (Table 3.5).

In 41.1 percent of the Worcester cases, the reason for the maltreatment according to the staff was the "mental condition of the perpetrator, including alcohol or drug abuse." The next most often cited reason (14.3 percent) was "long term interpersonal problems between abused and abusers." The Syracuse staff reported that in 39.6 percent of their cases, the abuser was "overwhelmed by the abused's needs dependency" and in 29.9 percent, it was "the mental condition." Findings from Rhode Island revealed the "mental condition" of the perpetrator to be the reason for 49.2 percent of the cases and "long term interpersonal problems," 20.0 percent (Table 3.6).

Another question asked whether the perpetrator was experiencing any one of twelve problems and the degree of severity: mild, moderate, severe or severity unknown. Almost two out of five of the perpetrators in each of the sites had a history of mental/emotional illness (Worcester, 40.7 percent; Syracuse, 38.7 percent; and Rhode Island, 37.3 percent).

TABLE 3.3 AGE, SEX, AND RACE OF THE PERPETRATORS

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Age			
10 to 19 years	1(1.7)	4(3.1)	4(3.4)
20 to 29	6(10.2)	7(5.4)	16(13.4)
30 to 39	10(16.9)	13(10.1)	25(21.0)
40 to 49	6(10.2)	21(16.3)	16(13.4)
50 to 59	10(16.9)	22(17.1)	23(19.3)
60 to 69	7(11.9)	33(25.6)	20(16.8)
70 to 79	8(13.6)	13(10.1)	9(7.6)
80 years and over	11(18.6)	16(12.4)	6(5.0)
No answer		6	15
b) Sex			
Male	42(71.2)	78(58.6)	84(66.1)
Female	17(28.8)	55(41.4)	43(33.9)
No answer		2	7
c) Race			
Native American	-	2(1.5)	2(1.6)
Black	-	11(8.3)	10(7.9)
Latino/Latina	2(3.4)	-	-
Asian	-	1(0.8)	-
White	57(96.6)	118(88.7)	112(88.2)
Other	-	1(0.8)	3(2.4)
No answer	-	2	7

TABLE 3.4 RELATIONSHIP OF PERPETRATORS TO VICTIMS

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Relationship of perpetrator to victim*:			
Husband	15(25.4)	27(20.0)	16(12.2)
Wife	5(8.5)	11(8.1)	6(4.6)
Son	14(23.7)	32(23.7)	46(35.1)
Daughter	11(18.6)	25(18.5)	24(18.3)
Sister	3(5.1)	4(3.0)	3(2.3)
Brother	3(5.1)	1(0.7)	3(2.3)
Brother/Sister-in-law	-	1(0.7)	-
Son/Daughter-in law	3(5.1)	5(3.7)	5(3.8)
Other relative	6(10.2)	18(13.3)	13(9.9)
Non-relative	7(11.9)	16(11.9)	22(16.8)
No answer	-	-	3
b) Perpetrator lives with victim:			
Yes	49(83.1)	91(70.0)	100(76.9)
No	10(16.9)	43(30.0)	30(23.1)
No answer		5	4
c) Number of years the perpetrator has lived with the victim (mean years):	25.6	20.7	22.8
d) Rating of the quality of the relationship between the victim and perpetrator at intake:			
Poor	44(77.2)	93(71.0)	83(79.0)
Good	12(21.1)	37(28.2)	19(18.1)
Excellent	1(1.8)	1(0.8)	3(2.9)
No answer	2	4	29

*Columns do not add up to 100 percent because of multiple responses to this question.

TABLE 3.5 STATED REASONS FOR ABUSE/NEGLECT BY PERPETRATORS*

	Worcester n=[illegible]	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
Perpetrator's stated reasons for abuse/neglect:			
Denial of problem	25(50.9)	35(27.8)	26(31.0)
Overwhelmed by victim's dependency	6(10.9)	45(35.7)	6(7.1)
Dislike, anger towards the victim	2(3.6)	22(17.5)	6(7.1)
Outside events induced stress reaction	2(3.6)	3(2.4)	1(1.2)
Triggered by events surrounding other family members	4(7.3)	8(6.3)	4(4.8)
Lack of concern	2(3.6)	11(8.7)	2(2.4)
Monetary gain	1(1.8)	5(4.0)	-
Self-defense	1(1.8)	2(1.6)	3(3.6)
Material gain	1(1.8)	3(2.4)	1(1.2)
Illness	2(3.6)	14(11.1)	8(9.6)
No apparent reason	2(3.6)	1(0.8)	1(1.2)
Can't be determined	13(23.6)	17(13.5)	34(40.5)
No answer	4	9	50

*Columns do not add to 100 percent because of multiple responses.

TABLE 3.6 SOCIAL WORKERS' ASSESSMENT OF THE REASONS FOR THE PERPETRATORS' ACTIONS*

Reasons for action	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
Overwhelmed by elder's needs dependency	10(17.9)	53(39.6)	14(10.8)
Dysfunctional family including violence	9(16.1)	9 (6.7)	25(19.2)
Mental status including alcohol-drug abuse	23(41.1)	40(29.9)	64(49.2)
Victim expects too much of perpetrator	3(5.4)	14(10.4)	7(5.4)
Long-term interpersonal problems between victim/ perpetrator	8(14.3)	26(19.4)	26(20.0)
Lack of concern for victim	4(7.1)	24(17.9)	13(10.0)
Lack of knowledge of perpetrator	2(3.6)	2(1.5)	6(4.6)
Financial	3(5.4)	32(23.9)	23(17.5)
Self-defense	1(1.8)	-	1(0.8)
Loss of independence	1(1.8)	2(1.5)	1(0.8)
Material gain	3(5.4)	24(17.9)	16(12.3)
Distrustful	-	4(3.0)	4(3.1)
Perpetrator expects too much of Victim	1(1.8)	6(4.5)	4(3.1)
No answer	3	1	4

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* Columns do not add to 100 percent because of multiple responses.

Similarly, almost the same percentage were alcohol abusers (Worcester, 34.5 percent; Syracuse 39.5 percent; and Rhode Island 44.1 percent). Generally, the cases were in the "moderate" to "severe" categories (See Table 3.20 for list of problems including mental illness and alcohol abuse).

Characterization of the Abuse and Neglect

Using the categories and descriptions provided in the assessment instrument (physical, psychological, material, and active and passive neglect, the staff of the Projects were requested to indicate the nature of the particular abuse evident in each case. In all three projects, the most prevalent type was psychological abuse, present in 72.9 percent of the Worcester cases, 72.1 percent of the Syracuse cases and 69.2 percent of the Rhode Island cases. The next most prevalent form varied among the sites: the Worcester staff reported that 44.1 percent of the cases involved physical abuse; 42.4 percent, passive neglect; 39.0 percent, material abuse; and 15.3 percent, active neglect. The Syracuse results show 55.0 percent, passive neglect; 38.6 percent, each, material and physical abuse; and 26.4 percent, active neglect. Rhode Island's list of types by prevalence also differs from the others with 52.2 percent physical abuse; 31.8 percent, material abuse; active neglect, 14.3 percent; and passive neglect, 11.3 percent. On the average, each case represented two types of abuse, usually psychological abuse and another form. When the workers were asked to indicate which type of abuse precipitated the reporting, a slightly different pattern of responses resulted in Worcester and Syracuse. For the former, physical abuse most often led to the referral (55.6 percent of the cases) followed by psychological (25.4 percent), material (23.9 percent), passive neglect (23.7 percent) and active neglect (6.8 percent). The latter listed passive neglect as the major cause for reporting (39.3 percent), psychological (38.5 percent), physical (28.9 percent), material, (24.4 percent) and active neglect (18.5 percent). For Rhode Island, the order ot prevalence for precipitating a referral was psychological abuse (56.0 percent), physical abuse (49.3 percent), material abuse (23.9 percent), and active (12.7 percent) and passive neglect (11.2 percent).

To probe further into the nature of abuse/neglect, the staff were requested to note which form of maltreatment they considered to be most harmful among their cases. The Worcester staff believed the psychological to be most detrimental (32.2 percent), then passive neglect (28.8 percent), physical abuse (33.8 percent), active neglect (10.5 percent) and material abuse (8.8 percent), while Syracuse found passive neglect to be the most injurious (38.0 percent) psychological (37.2 percent), physical abuse (24.8 percent) active neglect (17.8 percent) and material abuse (15.5 percent). Rhode Island workers reported physical abuse (53.5) to be the most harmful, then the psychological (28.3 percent), active neglect (15.6 percent), material abuse (14.5 percent) and passive neglect (13.0 percent).

Since earlier studies had shown that cases of abuse and neglect are usually long-standing, the intake assessment included a question on the length of time the individual was abused/neglected before being reported to the Model Project. For the Worcester group, with information on about three-quarters of the cases, there was a range from one month to forty years, with a median of 18 months. The Syracuse staff with data from seven-eighths of the cases recorded situations from 1 month to 20 years in duration with a medium of 12 months, and the Rhode Island clients had been victimized from one month fo 50 years with a median of 24 months (Table 3.7).

In order to learn more about the characteristics of the abuse and neglect, a list of forty manifestations was included on the assessment form. The social workers were requested to note whether each was present or not, and if present, the degree of severity (mild, moderate, severe, or present but severity unknown (?)) In the Worcester sample of 59 cases, the most often found manifestations of maltreatment were verbal assault (n=28), intimidation (23), and threats (22), in the moderate to severe category. The most prevalent type of neglect was lack of support/companionship found in 18 cases, and lack of supervision in 14. Material abuse was almost evenly divided between "taking possession of money or property" (18) and "misuse of money or property (16). Bruises and welts were the commonest manifestation of physical abuse (12 cases). Other acts of physical violence were present in only a few cases (Table 3.8).

A larger sample of cases (135) in Syracuse permits a better picture of the distribution of the manifestations of abuse and neglect. Again, there are more victims of psychological abuse than any other type. In the Syracuse sample, isolation is the most prevalent (88 cases), then intimidation (82) and humiliation (78), all generally of moderate severity. Neglect in the Syracuse cases appears to be characterized by lack of support/companionship found in 79 cases and next by lack of supervision noted in 57 cases, most of which were moderately severe. For the Syracuse sample, "misuse" of fund and or property was more often found (66) than "taking possession" (43). Bruises and welts again were the most common form of physical abuse (36) (Table 3.9).

Information about the 134 Rhode Island cases was not as complete as that for the other two Model Projects. However, similar to the Worcester findings, psychological abuse was manifested most often by verbal assault (78) and then intimidation (70), and in most instances, noted as "severe." Lack of personal care was the commonest form of neglect, noted in 30 cases out of the 71 for which there were data; next was lack of supervision noted in 28 cases. Twenty one elders were victimized by having their money or possessions taken by others while 14 cases showed "misuse of money or property." Bruises and welts and direct beatings were found in 21 cases while other forms of physical abuse were checked for only a few cases (Table 3.10). As a consequence of the behavior of the perpetrator, the case workers believed the situations to be life threatening or very threatening in 49.1 percent of the Worcester cases; 35.4 percent of the Syracuse cases and 71.5 percent of the Rhode Island cases (See Table 3.7).

TABLE 3.7 TYPES OF ABUSE AND NEGLECT REPORTED, LENGTH OF TIME THEY HAD BEEN OCCURRING, AND LEVEL OF THREAT TO VICTIM

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Type of abuse/neglect reported*:			
Physical	26(44.1)	54(38.6)	70(52.2)
Psychological	43(72.9)	101(72.1)	92(69.2)
Material	23(39.0)	54(38.6)	41(31.8)
Active neglect	9(15.3)	37(26.4)	19(14.3)
Passive neglect	25(42.4)	77(55.0)	15(11.3)
b) Type of abuse/neglect which precipitated the report*:			
Physical	21(35.6)	39(28.9)	66(49.3)
Psychological	15(25.4)	52(38.5)	75(56.0)
Material	14(23.7)	33(24.4)	32(23.9)
Active neglect	4(6.8)	25(18.5)	17(12.7)
Passive neglect	14(23.7)	53(39.3)	15(11.2)
c) Type of abuse/neglect considered most harmful*:			
Physical	13(22.8)	32(24.8)	70(53.5)
Psychological	19(32.3)	48(37.2)	37(28.3)
Material	5(8.8)	20(15.5)	19(14.5)
Active neglect	6(10.5)	23(17.8)	21(15.6)
Passive neglect	17(28.8)	49(38.0)	17(13.0)
d) Level of threat to the physical/mental health of of the victim:			
Life threatening	4(7.0)	9(6.8)	52(41.3)
Very threatening	24(42.1)	38(28.6)	38(30.2)
Moderately threatening	26(45.6)	61(45.9)	34(27.0)
Not really threatening at all	3(5.3)	25(18.8)	2(1.6)
No answer	2	2	8
e) Length of time person was abused/neglected:			
Mean (months)	39.8	19.3	71.6
Median (months)	18	12	24
Range (months–years)	1-40	1-20	1-50

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* Columns do not add to 100 percent because of multiple responses.

TABLE 3.8 MANIFESTATIONS OF ABUSE AND NEGLECT - WORCESTER

	None	Mild	Moderate	Severe	?	N/A
	#	#	#	#	#	#
Physical Abuse						
Bruises, welts	47	4	5	3	-	-
Sprains, dislocations	59	-	-	-	-	-
Malnutrition	59	-	-	-	-	-
Burns, scalding	58	-	1	-	-	-
Abrasions, lacerations	57	-	-	1	1	-
Wounds, cuts, punctures	58	-	-	1	-	-
Internal injuries	59	-	-	-	-	-
Dismemberment	59	-	-	-	-	-
Sexually molested	59	-	-	-	-	-
Oversedation	58	-	1	-	-	-
Hypothermia	59	-	-	-	-	-
Bone fractures	56	-	1	1	1	-
Skull fractures	59	-	-	-	-	-
Direct beatings	55	-	2	2	-	-
Forced into NH	59	-	-	-	-	-
Tied to bed	59	-	-	-	-	-
Tied to chair	59	-	-	-	-	-
Other physical confinement against will	59	-	-	-	-	-
Other	51	1	7	-	-	-
Psychological Abuse						
Verbal assault	28	1	13	11	3	3
Threat	34	-	8	12	2	3
Intimidation	33	1	8	12	2	3
Humiliation	38	1	7	10	-	3
Isolation	41	2	5	8	-	3
Other	53	-	-	1	-	5

TABLE 3.8 MANIFESTATIONS OF ABUSE AND NEGLECT (cont.) - WORCESTER

	None	Mild	Moderate	Severe	?	N/A
	#	#	#	#	#	#
Material Abuse						
Taking possession of money or property	39	1	8	8	1	2
Misuse of money or property	41	-	7	8	1	2
Other	52	-	1	3	-	3
Neglect						
Abandoned	51	2	1	5	-	-
Lack of help house cleaning	55	-	2	2	-	-
Lack of food	41	2	10	3	-	-
Lack of heat	53	-	2	4	-	-
Lack of personal care	47	1	3	8	-	-
Lack of supervision	45	1	6	7	-	-
Lack of support/companionship	41	1	10	7	-	-
Failure to purchase prescribed Rx	58	-	-	1	-	-
No false teeth when needed	57	-	-	2	-	-
No hearing aid when needed	57	1	-	1	-	-
No glasses when needed	56	-	1	2	-	-
Failure to provide other prescribed medical services	47	-	8	4	-	-
Failure to fulfill other caretaking obligations	42	2	6	8	1	-

TABLE 3.9 MANIFESTATIONS OF ABUSE AND NEGLECT - SYRACUSE

	None	Mild	Moderate	Severe	?	N/A
	#	#	#	#	#	#
Physical Abuse						
Bruises, welts	96	11	19	3	3	3
Sprains, dislocations	122	1	5	4	-	3
Malnutrition	119	3	8	2	-	3
Burns, scalding	127	2	3	-	-	3
Abrasions, lacerations	125	-	7	-	-	3
Wounds, cuts, punctures	129	-	3	-	-	3
Internal injuries	132	-	-	-	-	3
Dismemberment	132	-	-	-	-	3
Sexually molested	130	-	1	1	-	3
Oversedation	131	1	-	-	-	3
Hypothermia	131	1	-	-	-	3
Bone fractures	131	-	-	1	-	3
Skull fractures	131	-	1	-	-	3
Direct beatings	127	3	2	-	-	3
Forced into NH	131	1	-	-	-	3
Tied to bed	131	-	1	-	-	3
Tied to chair	130	1	1	-	-	3
Other physical confinement against will	116	2	7	6	2	3
Other	117	1	3	5	5	3
Psychological Abuse						
Verbal assault	68	6	39	18	1	3
Threat	80	7	31	14	-	3
Intimidation	51	10	54	17	1	2
Humiliation	55	12	45	18	3	2
Isolation	45	9	42	32	5	2
Other	117	-	5	2	5	6

TABLE 3.9 MANIFESTATIONS OF ABUSE AND NEGLECT (cont.) - SYRACUSE

	None	Mild	Moderate	Severe	?	N/A
	#	#	#	#	#	#
Material Abuse						
Taking possession of money or property	85	4	23	16	-	7
Misuse of money or property	61	11	31	23	1	8
Other	119	-	2	-	3	11
Neglect						
Abandoned	125	3	3	4	-	-
Lack of help house cleaning	96	7	16	15	1	-
Lack of food	79	11	27	16	2	-
Lack of heat	125	-	7	3	-	-
Lack of personal care	78	5	32	15	5	-
Lack of supervision	78	5	31	19	2	-
Lack of support/companionship	56	5	42	27	5	-
Failure to purchase prescribed Rx	105	4	13	12	1	-
No false teeth when needed	121	-	7	7	-	-
No hearing aid when needed	129	1	-	5	-	-
No glasses when needed	125	3	1	6	-	-
Failure to provide other prescribed medical services	96	1	16	18	4	-
Failure to fulfill other caretaking obligations	82	3	18	12	18	2

TABLE 3.10 MANIFESTATIONS OF ABUSE AND NEGLECT - RHODE ISLAND

	None	Mild	Moderate	Severe	?	N/A
	#	#	#	#	#	#
Physical Abuse						
Bruises, welts	104	2	7	9	3	9
Sprains, dislocations	122	-	1	2	-	9
Malnutrition	124	-	-	1	-	9
Burns, scalding	121	-	1	2	1	9
Abrasions, lacerations	121	-	1	3	-	9
Wounds, cuts, punctures	124	-	1	-	-	9
Internal injuries	124	-	-	1	-	9
Dismemberment	125	-	-	-	-	9
Sexually molested	124	-	1	-	-	9
Oversedation	125	-	-	-	-	9
Hypothermia	125	-	-	-	-	9
Bone fractures	119	-	-	5	1	9
Skull fractures	124	-	-	1	-	9
Direct beatings	104	-	4	17	-	9
Forced into NH	125	-	-	-	-	9
Tied to bed	124	-	-	1	-	9
Tied to chair	114	-	-	1	-	9
Other physical confinement against will	117	-	2	6	-	9
Other	85	2	10	23	4	10
Psychological Abuse						
Verbal assault	28	1	10	67	-	28
Threat	41	1	3	60	-	29
Intimidation	34	1	5	63	1	30
Humiliation	50	-	3	47	-	34
Isolation	70	1	5	21	-	37
Other	80	-	1	8	3	42

TABLE 3.10 MANIFESTATIONS OF ABUSE AND NEGLECT (cont.) - RHODE ISLAND

	None	Mild	Moderate	Severe	?	N/A
	#	#	#	#	#	#
Material Abuse						
Taking possession of money or property	42	-	2	18	1	71
Misuse of money or property	44	-	4	11	2	73
Other	46	-	4	8	2	74
Neglect						
Abandoned	64	-	1	6	-	63
Lack of help house cleaning	48	1	-	22	-	63
Lack of food	49	-	3	18	1	63
Lack of heat	62	1	-	7	-	64
Lack of personal care	41	1	3	26	-	63
Lack of supervision	43	-	5	23	-	63
Lack of support/companionship	47	-	3	19	1	64
Failure to purchase prescribed Rx	65	-	1	3	-	65
No false teeth when needed	68	-	-	1	-	65
No hearing aid when needed	69	-	-	-	-	65
No glasses when needed	67	-	-	2	-	65
Failure to provide other prescribed medical services	59	-	1	10	-	64
Failure to fulfill other caretaking obligations	45	-	1	20	5	63

Dependency and Exchange

Two approaches were used to learn what role dependency played in elder abuse and neglect situations: one was to determine the health and functional status of the abused/neglected elders, the second was to measure the degree of dependency of the elder in various categories. On the assessment form, the social workers were asked to list the major physical health problems of their clients, the total number of which was used in the study. There was an average of 2.8, for the Worcester cases; Syracuse 2.6; and Rhode Island, 2.0. In response to the question concerning the utilization of supportive devices, the social workers in Worcester found that more than half the abused elders used either a cane, walker, or wheelchair (51.9 percent); the Syracuse project staff reported 48.9 percent in that category; and Rhode Island 42 percent.

The next three questions concerned nutritional status. Special diets were prescribed for 34.7 percent of the Worcester victims, 27.7 percent of the Syracuse abused/neglected elders; and 21.4 percent of the Rhode Island cases. The assessment disclosed that 41.9 percent of the Worcester elders were not eating well, 55.8 percent of the Syracuse clients and 32.5 percent of those in the Rhode Island caseload. When asked whether there had been a significant change in weight, the case workers in Worcester reported that 70.7 percent of their clients had maintained their weight, in Syracuse, 41.4 percent; and in Rhode Island 67.3 percent (Table 3.11).

A series of instrumental tasks was listed on the assessment questionnaire to be marked either "yes" or "no" depending on whether the client had a problem in that area. Eight were included. Among the Worcester cases, the proportion of those having problems ranged from 51.7 percent with safety/security of personal property to 76.8 percent for general shopping. For the Syracuse group, the existence of problems went from 71.4 percent safety/security of personal property to 90.3 percent for transportation while those for the Rhode Island clients ranged from 20.4 percent for the safety/security of personal property to 89.8 percent for transportation (Table 3.12).

Concerning the cognitive status of the victim, there were several questions on the assessment form. First the social workers were asked to note whether the client had problems with orientation (person, place, time) and memory (immediate, recent, remote). About one-third of the Worcester abused/neglected elders were found to have a problem with orientation either all the time or some time (person, 35.2; place, 28.4; and time, 34.0) and more than half of the clients in the Syracuse project (person, 59.4; place 51.9; and time 62.8). The Rhode Island workers indicated about one-quarter of their clients had problems all or some of the time (person, 27.0 percent; place, 26.9 percent; and time 27.5 percent).

Responses to problems with memory follow a similar pattern with about one-third of the Worcester victims exhibiting memory impairment some or all of the time (immediate, 29.2 percent; recent, 40.0 percent; and remote, 32.4 percent), almost two-thirds of the Syracuse clients

TABLE 3.11 HEALTH/FUNCTIONAL STATUS OF THE ABUSED/NEGLECTED ELDERS

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Number of total physical impairments(meant)	2.78	2.56	1.97
b) Abused/neglected elder requires supportive devices for mobility:			
Yes	27(51.9)	64(48.9)	42(42.4)
No	25(48.1)	53(40.5)	53(53.5)
Bedridden	-	14(10.1)	4(4.0)
No answer	7	4	35
c) Abused/neglected elder is on a physican prescribed diet:			
Yes	17(34.7)	36(27.7)	18(21.4)
No	32(65.3)	94(72.3)	66(78.6)
No answer	10	5	50
d) Abused/neglected elder's weight has changed significantly compared to usual adult weight:			
Yes	5(12.2)	4(3.1)	3(6.1)
Less	7(17.1)	62(48.4)	11(22.4)
More	-	9(7.0)	2(4.1)
No	29(70.7)	53(41.4)	33(67.3)
No answer	18	7	85
e) Abused/neglected elder appears to be eating well:			
Yes	25(58.1)	57(44.2)	52(67.5)
No	18(41.9)	72(55.8)	25(32.5)
No answer	16	6	57

TABLE 3.12 ABUSED/NEGLECTED ELDERS' PROBLEMS WITH THE INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Problems	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Personal care			
Yes	42(72.4)	108(80.6)	73(56.2)
No	16(27.6)	26(19.4)	57(43.8)
No answer	1	1	4
b) Mobility/communications			
Yes	39(66.1)	112(83.6)	75(58.1)
No	20(33.9)	22(16.4)	54(41.9)
No answer	-	1	5
c) Mealtime activities			
Yes	44(74.6)	116(86.6)	73(56.2)
No	15(25.4)	18(13.4)	57(43.8)
No answer	-	1	4
d) Safety/security of personal property			
Yes	30(51.4)	95(71.4)	75(59.5)
No	28(48.3)	38(28.6)	51(40.5)
No answer	1	2	8
e) Management of financial/ personal affairs			
Yes	44(74.6)	119(88.8)	69(53.9)
No	15(25.4)	15(11.2)	59(46.1)
No answer	-	1	6
f) General shopping			
Yes	40(76.8)	119(88.8)	82(63.6)
No	19(32.2)	15(11.2)	47(36.4)
No answer	-	1	5
g) Transportation			
Yes	42(71.2)	121(90.3)	81(62.8)
No	17(28.8)	13(9.7)	48(37.2)
No answer	-	1	5
h) Household management			
Yes	43(74.1)	113(85.0)	80(61.1)
No	15(25.9)	20(15.0)	51(38.9)
No answer	1	2	3

(immediate, 62.2 percent; recent, 64 percent; and remote, 56.8 percent) and slightly more than one-quarter of the Rhode Island victims (immediate 29.5 percent; recent, 30.0 percent; and remote, 28.4 percent) (Table 3.13).

In response to questions about the abused person's emotional state at intake the social workers reported that a majority were in a "poor" state (Worcester, 58.8 percent; Syracuse, 72.6 percent; and Rhode Island, 71.7 percent). Yet, the workers found 81.6 percent of the cases, in Worcester, 84.8 percent in Syracuse, and 86.4 percent in Rhode Island were able to give consent. The answers to the final question on the emotional and mental status indicated variation in the three Projects; 44.4 percent of the Worcester victims were reported to have very or moderately low level of self esteem, 82.1 percent of the Syracuse and 65.5 percent of the Rhode Island clients (Table 3.14).

To learn more about dependency as a factor in elder abuse and neglect, the case workers were asked to rate the extent to which the abused/neglected person had been dependent on the abuser and/or his/her family in six different aspects of living: companionship, daily needs, financial management, financial resources, maintenance of property and transportation. The highest proportion of dependency among the Worcester cases was associated with financial management; 64.3 percent of the abused elders were very dependent in this area, next was companionship, which involved 62.1 percent of the cases. The Syracuse victims also were most dependent in this latter category; only 4.6 percent of the sample were independent and 81.5 percent very dependent. Generally, the Syracuse group appear to be dependent in most of the areas listed except for financial resources, 61.7 percent of the sample are independent of the abuser, and 19.2 percent are very dependent. Again, the largest percentage of dependent cases among the Rhode Island clients is in the area of support/companionship with 26.6 percent independent of the abuser, but 1.3 percent very dependent. Likewise, the greatest number of independent cases are associated with financial resources, 86.7 percent of the sample with only 7.5 percent as dependent (Table 3.15).

Because the earlier analysis of cases reported by community agencies (see "Preliminary Findings," p. 69) disclosed that abusers were often dependent on the abused for finances and other types of assistance a similar question was included in the case assessment regarding the abuser's dependency on the abused in the areas of finances, companionship, activities of daily living and other. Unfortunately, obtaining information about the abusers was difficult; therefore, the data are available for only a portion of the total sample on some of the items. They show that the situation for the abuser is the opposite that of the abused; the abuser is dependent on the abused for financial resources but apparently independent regarding companionship, and daily needs. Among the Worcester cases. 41.9 percent of the abusers are very dependent, for financial resources, and 32.6 percent slightly dependent and 25.6 independent. The Syracuse results indicate that 36.8 percent of the abusers are very dependent in this area 22.4 percent, slightly dependent and 40.8 percent, independent, and the findings from Rhode

TABLE 3.13 RATING OF MENTAL STATUS OF THE ABUSED/NEGLECTED ELDERS

		Worcester n=59	Syracuse n=135	Rhode Island n=134
		# %	# %	# %
a) Problems with orientation				
Person:	Yes	6(11.1)	17(13.3)	10(10.9)
	Sometimes	13(24.1)	59(46.1)	12(13.1)
	No	25(64.8)	52(40.6)	70(76.1)
	No answer	5	7	42
Place:	Yes	6(11.3)	20(15.5)	12(12.9)
	Sometimes	8(15.1)	47(36.4)	13(14.0)
	No	39(73.6)	62(48.1)	68(73.1)
	No answer	6	6	41
Time:	Yes	8(15.1)	21(16.3)	12(13.2)
	Sometimes	10(18.9)	60(46.5)	13(14.3)
	No	35(66.0)	48(37.2)	66(72.5)
	No answer	6	6	43
b) Problems with memory				
Immediate:	Yes	8(16.7)	28(21.3)	14(15.4)
	Sometimes	6(12.5)	52(40.9)	11(12.1)
	No	34(70.8)	48(37.8)	66(72.5)
	No answer	11	8	43
Recent:	Yes	8(17.8)	26(20.3)	14(15.6)
	Sometimes	10(22.2)	56(43.8)	13(14.4)
	No	27(60.0)	46(35.9)	63(70.6)
	No answer	14	7	44
Remote:	Yes	5(13.5)	22(17.6)	13(14.8)
	Sometimes	7(18.9)	49(39.2)	12(13.6)
	No	25(67.6)	54(43.2)	63(71.6)
	No answer	22	10	46

TABLE 3.14 RATING OF EMOTIONAL STATUS OF ABUSED/NEGLECTED ELDER

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Emotional state			
Excellent	0(0.0)	2(1.6)	1(1.0)
Good	21(41.2)	32(25.8)	27(27.3)
Poor	30(58.8)	90(72.6)	71(71.7)
No answer	8	11	35
b) Self-esteem			
Very low	2(5.6)	24(21.4)	24(27.6)
Moderately low	14(38.9)	68(60.7)	33(37.9)
Moderately high	20(55.6)	17(15.2)	23(26.4)
Very high	-	3(2.7)	7(8.1)
No answer	23	23	47
c) Abused/neglected elder can give consent			
Yes	40(81.6)	106(84.8)	95(86.4)
No	9(18.4)	19(15.2)	15(13.6)
No answer	10	10	24

TABLE 3.15 EXTENT OF DEPENDENCE OF ABUSED/ELDER ON THE ABUSER OR FAMILY

	Independent	Slightly Dependent	Very Dependent	N/A
	# %	# %	# %	#
Worcester (n=59)				
Companionship	12(20.7)	10(17.2)	36(62.1)	4
Daily needs	22(37.9)	5(8.6)	31(53.4)	1
Financial management	18(32.1)	2(3.6)	36(64.3)	3
Financial resources	29(52.7)	15(27.3)	11(20.0)	4
Maintenance of property	19(34.5)	9(16.4)	27(49.1)	4
Transportation	21(38.9)	4(7.4)	29(53.7)	5
Other	-	-	11	48
Syracuse (n=135)				
Companionship	6(4.6)	18(13.8)	106(81.5)	5
Daily needs	16(12.4)	17(13.2)	96(74.4)	6
Financial management	19(14.6)	22(16.9)	89(68.5)	5
Financial resources	74(61.7)	23(19.2)	23(19.2)	15
Maintenance of property	12(10.3)	19(16.4)	85(73.3)	19
Transportation	25(20.5)	13(10.7)	84(68.9)	13
Other	1	2	9	123
Rhode Island (n=134)				
Companionship	33(26.6)	15(12.1)	76(61.3)	10
Daily needs	56(45.5)	15(12.2)	52(42.3)	11
Financial management	70(58.3)	13(10.8)	37(30.8)	14
Financial resources	104(86.7)	7(5.8)	9(7.5)	14
Maintenance of property	41(39.4)	12(11.5)	51(49.0)	30
Transportation	51(45.5)	8(7.2)	53(47.3)	22
Other	7	1	7	119

Island also disclose that 54.5 percent of the perpetrator are dependent on the victim for finances, 23.4 percent, slightly dependent, and 22.1 percent, independent (Table 3.16).

Stress

Several questions were placed on the assessment form to test the hypothesis that the burden of caring for an elderly relative as well as the physical, mental, social or economic stresses on the abuser may lead to abuse or neglect. According to the social workers at the three Project sites, there was a great deal of stress evident in the lives of these families. . Two-thirds of the Worcester cases involved an abuser under "a lot" of stress (66.7 percent) as did, over one-half of the Syracuse case load (56.5 percent) and Rhode Island (55.7 percent). When asked to be more specific about the type of stress, the Worcester staff wrote "demands for attention" for over one-third of the cases (37.5 percent), and "incontinence" for one-quarter (28.1 percent). One-half of the Syracuse responses cited "unrealistic expectations" (50.9 percent) and two out of five (40.5), "demand for attention." Rhode Island workers noted that three out of ten (29.9 percent) abused had unrealistic expectations and a little over one-quarter (26.9 percent) made "demands for attention" (Table 3.17).

Because the abuse/neglect might have been precipitated by cer[illegible] changes in the situation of either the victim or the perpetrator, the social workers were given a list (physical health, mental health, loss of supports/contact, family relationships, financial or job status, living arrangements, increased dependency, and provocative behavior) and asked to rate whether any of them had occurred. In answer to the question about the victim, the Worcester staff checked "physical health" most often (81.0 percent of the cases) and then "increased dependency" "mental health" (61.0 percent). The Syracuse Project personnel indicated that 88.0 percent of their abused clients showed "increased dependency" and then changes in "physical health" (82.1 percent of cases). The Rhode Island responses indicated that 60.8 percent of the sample had "physical health" changes which exacerbated or precipitated the abuse situation; next most common response was "increased dependency" (51.5 percent).

Regarding the perpetrators the most frequently mentioned change among the Worcester cases was "mental health" (45.8 percent) and "living arrangements" (41.4 percent). In Syracuse, it was "family relationships" (59.5 percent) and "mental health" (53.0 percent) while in Rhode Island the most frequently found changes included "provocative behavior" and "financial or job status" (23.8 percent) (Table 3.18).

To learn more about the role of stress as a causal factor in cases of elderly mistreatment, the case workers were also asked to note whether certain problems (recent and long term medical and financial problems recent divorce or death of spouse; birth of a child, or suicide attempt) had occurred in the lives of the perpetrators and to what extent. Of all the problems listed, the most common noted in the Worcester case load was "long term medical problem" (27.1 percent of the cases); next, was "recent medical complaint" (18.6 percent). The

TABLE 3.16 EXTENT OF DEPENDENCE OF THE ABUSER ON THE ABUSED/NEGLECTED ELDER

	Independent	Slightly Dependent	Very Dependent	N/A
	#	#	#	#
Worcester (n=59)				
Companionship	1	4	7	47
Daily needs	1	-	7	51
Financial resources	11 (25.6)	14 (32.6)	18 (41.9)	16
Other	1	1	6	51
Syracuse (n=135)				
Companionship	1	5	11	118
Daily needs	-	-	2	133
Financial resources	51 (40.8)	28 (22.4)	46 (36.8)	10
Other	3	2	7	123
Rhode Island (n=134)				
Companionship	1	3	14	116
Daily needs	1	9	-	124
Financial resources	17 (22.1)	18 (23.4)	42 (54.5)	57
Other	4	1	30	99

TABLE 3.17 STRESSFUL EVENTS IN THE LIVES OF THE PERPETRATORS

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Victim is a source of stress to perpetrator or family			
A lot	24(66.7)	74.56.5)	49(55.7)
A little	5(13.9)	42(32.1)	18(20.5)
Not at all	7(19.4)	15(11.5)	21(23.9)
No answer	23	4	46
b) Type of stress*			
Soiling	8(25.0)	24(20.7)	9(13.4)
Verbal	6(18.8)	35(30.2)	9(13.4)
Demands for attention	12(37.5)	47(40.5)	18(26.9)
Wandering	4(12.5)	22(19.0)	5(7.5)
Unrealistic expectations	7(21.9)	59(50.9)	20(29.9)
Incontinence	9(28.1)	31(26.7)	11(16.4)
Others	22(68.8)	59(50.9)	39(58.2)
No answer	27	19	67
c) Perpetrator has unrealistic expectations of the victim:			
Yes	19(67.9)	59(51.3)	43(84.3)
No	9(32.1)	56(48.7)	8(15.7)
No answer	31	20	83

*Columns do not add to 100 percent because of multiple responses.

TABLE 3.18 CHANGES IN THE SITUATION OF THE VICTIMS AND PERPETRATORS WHICH MAY HAVE PRECIPITATED OR EXACERBATED THE ABUSE/NEGLECT*

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Changes in situation of victims			
Physical health	48(81.4)	110(82.1)	79(60.8)
Mental health	36(61.0)	71(52.6)	38(29.2)
Supports/contacts	21(35.6)	78(57.8)	32(24.6)
Family relationships	23(39.0)	87(64.4)	35(26.9)
Financial or job status	5(8.5)	15(11.2)	5(3.8)
Living arrangements	22(37.3)	73(54.1)	26(20.0)
Increased dependency	36(61.0)	119(88.1)	67(51.5)
Provocative behavior	22(37.3)	54(40.3)	9(6.9)
Other	12(20.3)	23(17.3)	8(6.2)
b) Changes in situation of perpetrators			
Physical health	23(39.0)	52(39.4)	21(16.7)
Mental health	27(45.8)	70(53.0)	40(31.7)
Supports/contacts	10(17.2)	57(43.2)	22(17.5)
Family relationships	23(39.7)	78(59.5)	32(25.4)
Financial or job status	20(33.9)	61(46.2)	30(23.8)
Living arrangements	21(41.4)	55(42.0)	21(16.7)
Increased dependency	7(12.1)	33(25.2)	30(23.8)
Provocative behavior	8(13.8)	38(29.0)	80(63.7)
Other	8(13.8)	13(9.9)	6(4.9)

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*Each of the above items appeared on the Case Assessment form with a choice of Yes or No. Above percentages represent the Yes answers. Columns do not add to 100 percent because of multiple responses.

Syracuse case workers recorded the presence of a "recent medical" and "financial problem" in 43.6 percent of their cases while Rhode Island found "long-term financial problems" in 39.0 percent of their cases and "long-term medical" in 14.4 percent (See Table 3.19 and Table 3.20 for percentages of cases with problems of any degree of severity).

Social Networks and Isolation

The initial plan of the Evaluation Team to obtain a detailed accounting of the number of persons with whom the victim had social contact, the type of contact, purposes, and frequency, could not be completed correctly in the format presented to the social workers. Instead, the the number of social contacts for the abused/neglected person was recorded excluding the perpetrator and formal caregivers (e.g., homemakers, nurses, friendly visitors, lawyers, parish priests, etc.); the frequency in with which they saw these people (daily, weekly or monthly/infrequently); and attendance at clubs/center activities or church on a regular basis (yes/no). The results from the Worcester sample show that almost one in five had no other social contact than those in the household or the perpetrator while about one in twenty had five or more contacts. For almost two out of five, the contact was on a weekly basis, one out of five monthly or infrequently and one out of five, daily. Approximately one out of seven had attended club or church programs.

One in six of the Syracuse cases had no social contact and slightly less than one in four had five or more contacts. About one-fifth saw people on a daily basis, two fifths weekly and one fifth monthly or less frequently. Only 7.0 percent of the Syracuse group attended club or church activities. A still lower percentage of the Rhode Island cases had contact with others (3.9 percent); slightly less than three out of ten of the Rhode Island abused elders had no social contact while a little more than one in twenty had five or more persons coming to see them. Visits to the Rhode Island abused occurred on a daily basis for almost one-third of the cases (31.8), weekly for about one quarter and infrequently for about one third (Table 3.21).

For the perpetrators, the results show that a larger majority had family members available for support and assistance (77.3 percent, Worcester; 69.6 percent, Syracuse; and 84.2 percent, Rhode Island) and even a larger proportion had someone to call in a crisis (89.7 percent, Worcester; 95.2 percent, Syracuse; and 90.4 percent, Rhode Island (Table 3.22).

Cycle of Violence

Obtaining information about the background of the perpetrators proved to be a difficult task. Even though the case workers spent many weeks and often months on the cases, they were not able to find out much about the childhood of the perpetrators or whether they had been responsible for other violent acts. Concerning the childhood experiences, responses were given for only 9 cases of the Worcester sample (n=59), of which 7 reported having been abused or neglected. For the 32 Syracuse

TABLE 3.19 SEVERITY OF PERPETRATORS' PROBLEMS

	None	Mild	Moderate	Severe	?	N/A
	#	#	#	#	#	#
Worcester (n=59)						
Alcohol abuse	38	7	8	3	2	1
Drug abuse	55	-	-	2	1	-
History of mental illness	35	2	9	12	1	-
Lack of needed service	49	-	5	5	-	-
Long-term financial problem	49	-	4	3	-	-
Long-term medical problem	43	3	7	6	-	-
Past suicide attempt	55	-	2	2	-	-
Recent birth of child	58	-	1	-	-	-
Recent financial problem	51	-	4	4	-	-
Recent divorce/separation	52	-	3	2	2	-
Recent death of spouse/ significant other	56	-	1	2	-	-
Recent medical complaint	48	-	9	2	-	-
Other	40	2	8	7	2	-
Syracuse (n=135)						
Alcohol abuse	75	12	14	23	-	11
Drug abuse	105	7	9	3	-	11
History of mental illness	76	10	21	15	2	11
Lack of needed service	57	5	34	23	5	11
Long-term financial problem	79	5	21	14	2	11
Long-term medical problem	78	2	21	21	2	11
Past suicide attempt	120	-	1	3	-	11
Recent birth of child	123	-	-	1	-	11
Recent financial problem	71	6	29	16	3	11
Recent divorce/separation	102	2	11	7	2	11
Recent death of spouse/ significant other	111	5	5	3	-	11
Recent medical complaint	70	8	22	18	6	11
Other	103	3	5	8	5	11
Rhode Island (n=134)						
Alcohol abuse	66	2	14	34	2	16
Drug abuse	103	-	4	8	3	16
History of mental illness	75	1	6	34	2	16
Lack of needed services	103	-	2	12	1	16
Long-term financial problem	72	1	5	40	-	16
long-term medical problem	101	1	4	12	-	16
Past suicide attempt	112	-	-	6	-	16
Recent birth of child	116	-	-	2	-	16
Recent financial problem	107	-	3	8	-	16
Recent divorce/separation	102	-	-	11	5	16
Recent death of spouse/ significant other	110	-	1	6	-	16
Recent medical complaint	110	-	3	5	-	16
Other	105	-	-	8	4	17

TABLE 3.20 NUMBER AND PERCENT OF PERPETRATORS HAVING PROBLEMS ASSESSED AS MILD TO SEVERE

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
Alcohol abuse	20(34.5)	49(39.5)	52(44.1)
Drug abuse	3(5.2)	19(15.3)	15(12.7)
History of mental illness	24(40.7)	48(38.7)	43(36.4)
Lack of needed service	10(17.0)	67(54.0)	15(12.7)
Long-term financial problem	7(12.5)	42(33.9)	46(39.0)
Long-term medical problem	16(27.1)	46(37.1)	17(14.4)
Past suicide attempt	4(6.8)	4(3.2)	5(5.1)
Recent birth of child	1(1.7)	1(0.8)	2(1.7)
Recent financial problem	8(13.6)	54(43.6)	11(9.3)
Recent divorce/separation	7(11.9)	22(17.7)	16(13.6)
Recent death of spouse/ significant other	3(5.1)	13(10.5)	7(5.9)
Recent medical complaint	11(18.6)	54(43.6)	.8(16.8)
Other	19(32.2)	21(16.9)	12(10.2)
No answer		11	16

TABLE 3.21 SOCIAL NETWORKS OF THE ABUSED/NEGLECTED ELDERS

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Number of persons with whom abused/neglected elder has social contacts excluding household members, perpetrator, and formal supports:			
None	11(18.6)	21(15.8)	36(28.3)
1	8(13.6)	25(18.8)	33(26.0)
2	15(25.4)	27(20.3)	26(20.5)
3	13(22.0)	26(19.5)	13(10.2)
4	8(13.6)	10(7.5)	11(8.7)
5 or more	4(6.8)	24(18.0)	8(6.3)
No answer	-	2	7
b) Frequency of contacts:			
Daily	11(21.2)	30(22.6)	35(31.8)
Weekly	20(38.5)	56(42.1)	26(23.6)
Monthly/infrequently	11(21.2)	26(19.6)	12(40.9)
None	10(19.2)	21(15.8)	37(33.6)
No answer	7	2	4
c) Abused/neglected elder attends clubs/church activities:			
Yes	8(13.8)	8(7.0)	5(3.9)
No	50(86.2)	107(93.0)	123(96.1)
No answer	1	20	6
d) Abused/neglected has someone to call in a crisis:			
Yes	42(93.3)	88(69.3)	106(92.2)
No	2(4.4)	39(30.7)	9(7.8)
No answer	15	8	19

TABLE 3.22 SOCIAL NETWORK OF THE PERPETRATORS

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Perpetrator has family members available for support or assistance:			
Yes	34(77.3)	80(69.6)	64(84.2)
No	10(22.7)	33(30.4)	12(15.8)
No answer	15	21	58
b) Perpetrator has someone to call in a crisis:			
Yes	35(89.7)	100(95.2)	66(90.4)
No	4(10.3)	3(4.8)	7(9.6)
No answer	20	30	61

responses, 14 had been maltreated themselves. Rhode Island furnished information on 32 perpetrators, of which 11 had been victimized as children. When the question was re-worded to find out whether the perpetrator had came from an unstable or untraditional background, data were available in only 20 Worcester cases, 5 of which checked "violence." Forty-two responses on the Syracuse assessments included 6 cases in which the perpetrators had had a violence childhood and the data from 39 Rhode Island cases, indicated nine cases with a violent childhood. Another question on this aspect of the perpetrator's background requested information about other acts of violence carried out by the perpetrator. Responses to 12 of the 59 Worcester cases were given: 2, child abuse; 1, spouse abuse; 5 documented assault and battery; and 4, other types. The Syracuse assessments forms included an answer to this question: 21, said "no acts;" 8, child abuse, 6 spouse abuse; 4 documented assault; and 4, "other." Rhode Island had information on 29 cases of which 4 were "none," 2, child abuse, 6 spouse abuse, 9 documented assault and battery and 10, other (Table 3.23).

Intervention, Action and Barriers

A final group of questions on the assessment form concerned the Model Project activities. The first dealt with the source of referral. Almost half of the Worcester cases were referred from private agencies (47.5 percent). Other sources, such as self-report, family members, hospitals, and public agencies, each accounted for about one-eighth of the case load (11.9 percent). Only one case was referred by a private physician and none by members of the legal profession. One in two of the Syracuse cases came from public agencies (48.9 percent); one in seven from private agencies; and one in eight from members of the victims' families and very few referrals from other sources. Two cases were referred by lawyers and none by private physicians. The largest proportion of cases reported to the Rhode Island Project came from public agencies' (27.8 percent) and the next highest percentage from both members of the family and private agencies (18.0 percent). Self-report by the victims occurred in 15.8 percent of the cases. Two situations were referred by private physicians and three by lawyers (3.24).

In response to the question about the services utilized by the abuse/neglected persons just prior to the agency's intervention, the Worcester staff cited health services in almost two out of three cases (65.3 percent) and informal supports for one out of two (49.0 percent). Relatively few abused persons were involved with meals on wheels, senior centers, legal services or volunteers. Three-quarters of the Syracuse case load had received health services (75.2 percent), slightly less than one-quarter (23.0), informal supports and one-fifth (20.4 percent), homemakers. Again, senior centers, legal services, outreach programs were rarely mentioned. More than four out of five Rhode Island cases were using health services, two out of five informal supports (43.9 percent) and one out of five (21.1 percent), homemakers. A small number of cases had been receiving meals on wheels, legal services and volunteers and attending senior centers (Table 3.25).

TABLE 3.23 BACKGROUND OF VIOLENCE IN THE LIVES OF THE PERPETRATORS

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Background of the perpetrator*:			
Single parent	4(20.0)	1(2.3)	4(10.3)
Non-parental	-	10(23.3)	3(7.7)
Step-parent	-	1(2.3)	1(2.6)
Violence	5(25.0)	6(14.0)	9(20.9)
Other	12(60.0)	29(57.4)	26(60.5)
No answer	39	92	95
b) Perpetrator was abused/neglected as a child:			
Yes	7(77.8)	14(43.8)	11(35.5)
No	2(22.2)	18(56.3)	20(64.5)
No answer	50	103	103
c) Perpetrator has been responsible for additional acts of abuse/neglect to others*:			
Child abuse	2(22.2)	8(22.2)	2(8.0)
Spouse abuse	1(11.1)	6(16.7)	6(24.0)
Documented assault and/or battery	5(55.6)	4(11.1)	9(36.0)
Others	4(44.4)	4(11.1)	10(40.0)
No	-	21(58.3)	4(16.0)
No answer	50	99	109

*Columns do not add to 100 percent because of multiple responses.

TABLE 3.24 SOURCE OF CASE REFERRAL TO THE MODEL PROJECTS*

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
Personal observation	1(1.7)	-	1(0.8)
Client (self-report)	7(11.9)	3(2.2)	21(15.8)
Member of client's family	7(11.9)	16(11.9)	24(18.0)
Hospital or clinic	7(11.9)	8(5.9)	9(6.8)
Police	-	2(1.5)	4(3.0)
Private physician	1(1.7)	-	2(1.5)
Lawyer/paralegal	-	2(1.5)	3(2.3)
Client's friend or neighbor	4(6.8)	8(5.9)	12(9.0)
Private agency	28(47.5)	21(15.6)	24(18.0)
Public agency	7(11.9)	66(48.9)	37(27.8)
Co-worker	3(5.1)	-	1(0.8)
Other	4(6.8)	20(14.8)	7(5.3)

* Column totals do not add up to 100 percent because of multiple responses to this question.

TABLE 3.25 SERVICES PROVIDED TO THE ABUSED/NEGLECTED ELDERS PRIOR TO AND IMMEDIATELY AFTER MODEL PROJECT INTERVENTION*

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Services used by abused/neglected slder just prior to Model Project intervention:			
Health services	32(65.3)	85(75.2)	101(82.1)
Meals on wheels	4(8.2)	14(12.4)	9(7.3)
Senior centers	3(6.1)	4(3.5)	14(11.4)
Outreach programs	6(12.2)	5(4.4)	9(7.3)
Homemakers	7(14.3)	23(20.4)	25(21.1)
Legal services	2(4.1)	4(3.5)	12(9.8)
Volunteers	1(2.0)	8(7.1)	5(4.1)
Informal supports	24(49.0)	26(23.0)	54(53.9)
Other	14(28.6)	32(28.3)	59(48.0)
No answer	10	22	11
b) Initial action taken by Model Project:			
Contacted victim	26(44.8)	27(24.3)	18(14.0)
Counseling victim	7(12.1)	5(4.5)	34(26.4)
Homemaker service/food	7(12.1)	49(44.1)	12(9.3)
Legal services	11(19.0)	6(5.4)	29(22.5)
Contacted other involved agencies	22(37.9)	52(46.8)	65(50.4)
Family intervention	9(16.5)	8(7.2)	18(14.0)
Contacted perpetrator	13(22.4)	10(9.0)	7(5.4)
Counseling perpetrator	3(5.2)	10(9.0)	12(9.3)
Medical care	4(6.9)	16(14.4)	14(10.9)
Changed living arrangements	10(17.2)	13(11.7)	22(17.1)
Evaluation/case conference	10(17.2)	19(17.1)	16(12.4)
Financial assistance	3(5.2)	1(0.9)	8(6.2)
Police protection	4(6.9)	1(0.9)	22(17.1)
Day center services	3(5.9)	5(4.5)	6(4.7)
Hospitalizaton	4(6.9)	8(7.2)	9(7.0)
Neighbor support	2(3.4)	3(2.7)	2(1.6)
Transportation	-	1(0.9)	3(2.3)
No answer	1	24	5

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*Columns do not add up to 100 percent because of multiple responses.

Initial action taken by the Projects covered a wide array of services. Most often cited by the Worcester staff was "contacting the victim" (in 44.8 percent of the cases) and then "other agencies" (37.9 percent of the cases). Syracuse listed "contacting other agencies" (46.8 percent) and next "providing homemaker service (case aides). Rhode Island also mentioned "contacting other agencies" for 50.4 percent of their cases and then "counseling the victim (26.4 percent).

To determine the referral patterns used by the Model Projects, the case workers were requested to specify the various agencies to which they had made referrals for each of the cases in five categories: medical, mental health, social service, volunteer, police, legal and others. For most Worcester cases, there was one referral per category, although on behalf of one case the staff made four "medical" contacts (i.e., physician, dental clinic, eye specialist, and VNA). The rank order of the types of agency referrals begins with medical (29 out of 59 cases were referred for medical services 49.2 percent), mental health (27.1 percent), social service (27.1 percent), legal (23.7 percent), police (17.0 percent) and volunteers (3.4 percent). "Others" included housing, foster care, day care, rest home, meals on wheels, etc.

The greater proportion of referrals in the Syracuse case load was to social service agencies (64.9 percent of cases were referred to social service agencies), then medical (51.7 percent), mental health (34.3 percent), volunteer groups (34.3 percent), police (13.4 percent), and legal (9.0 percent). Under the "other" category, the Syracuse project listed on the referral to their Aide program (16.4 percent) and parish priests/outreach workers (6.7 percent). The Rhode Island project staff made referrals to social service agencies for 45.5 percent cases, to medical services for mental health for 33.1 percent, police, 36 percent, legal, 17.4 percent and volunteer 9.1 percent. In 21.8 percent of the cases, referrals included more than one social service agency. Listed under "other" were housing, employment, relative, and priest (Table 3.26 and 3.27 the percentage of cases for each category).

A separate group of questions were included on legal action the first of which was whether the case worker thought that any legal action was appropriate. For about one-third (32.2 percent) of the Worcester cases, the answer was "yes;" for 44.1 percent, "not sure". Syracuse reported affirmatively for 11.2 percent of the cases and "not sure" for 42.5 percent while the Rhode Island staff said "yes" for 38.1 percent and "not sure" for 47.8 percent. When requested to specify the type of legal action, the Worcester case workers most often added "order of protection," and "competency" (each 5 cases); Syracuse, "order of protection, "criminal action, and involuntary commitment" (each 2 cases); and Rhode Island "order of protection" (8 cases); "criminal action" (6 cases) and "involuntary commitment" (3 cases).

In response to the inquiry whether they had initiated or planned to initiate any of these legal interventions, the Worcester staff said "yes" for only one-quarter of the cases, Syracuse for less than one in ten (7.8 percent) and Rhode Island for about 10 percent. Further questioning concerning the effect of mandatory reporting on the case showed

TABLE 3.26 NUMBER OF REFERRALS MADE TO COMMUNITY AGENCIES BY TYPE PER CASE OF ELDER ABUSE/NEGLECT

	None	1	2	3	4	N/A
	#	#	#	#	#	#
Worcester (n=59)						
Medical	30	24	3	1	1	-
Mental Health	42	16	1	-	-	-
Social Service	38	16	5	-	-	-
Volunteer	57	2	-	-	-	-
Police	49	10	-	-	-	-
Legal	45	14	-	-	-	-
Other	48	9	3	1		
Syracuse (n=135)						
Medical	53	70	10	2	-	-
Mental Health	86	46	2	-	-	1
Social Service	33	87	11	3	-	1
Volunteer	88	46	-	-	-	1
Police	116	18	-	-	-	1
Legal	122	12	-	-	-	1
Other	73	61	-	-	-	1
Rhode Island (n=134)						
Medical	82	44	7	-	-	1
Mental Health	92	40	1	-	-	1
Social Service	43	61	22	4	3	1
Volunteer	118	12	2	-	-	2
Police	96	36	-	-	-	2
Legal	109	23	-	-	-	2
Other	101	31	-	-	-	2

TABLE 3.27 NUMBER AND PERCENT OF CASES REFERRED TO COMMUNITY AGENCIES BY TYPE OF AGENCY

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
Medical	29(49.2)	82(60.7)	51(38.4)
Mental Health	17(28.8)	48(35.8)	41(30.8)
Social Services	21(35.6)	101(75.4)	90(67.7)
Volunteer	2(3.4)	46(34.3)	14(10.6)
Police	10(17.0)	18(13.4)	36(27.3)
Legal	14(23.7)	12(9.0)	23(17.4)
Other	13(22.0)	61(45.5)	31(23.5)
No answer		1	2

that the Worcester staff felt that such a piece of legislation in one out of six cases would have helped to bring about an earlier and/or more effective intervention while Syracuse thought that one in eight of the cases might have been helped (Mandatory reporting was already in effect in Rhode Island). Asked whether in their opinion a short term involuntary protective removal law would have made an earlier and more effective intervention possible, the Worcester staff replied negatively for almost all cases (95.6 percent); Syracuse for 82 percent and Rhode Island for 73.5 percent (Table 3.28).

The last question on the case assessments presented a list of barriers to effective service delivery and asked the case workers to rate them in terms of the degree to which they had hindered or were likely to hinder the delivery or appropriate services to their cases (not hindered, hindered a little, hindered a lot, or not applicable). The least hindrance for the Worcester cases was attributed to "number of agencies involved" (91.2 percent of the cases were not hindered by it) and "coordination of services" (89.2 percent). The most frequently mentioned barriers were "receptivity of the abuser to help (cited as a barrier in 86.9 percent of the cases) and "receptivity of the abused" (63.6 percent). The Syracuse staff found that the least hindrance was the "number of agencies involved" (95.0 percent of cases were not hindered by it) and "lack of protective services" (93.3 percent), while "lack of receptivity of the abuser to help" (hindered in 88.8 percent of the cases) and "receptivity of the abused to help" (73.6) were the most often listed barriers. The "number of agencies involved" and "non-reimbursement for services" did not hinder service delivery in any of the cases by the Rhode Island staff but in 83.8 percent of the cases "receptivity of the abuser" was found to be a barrier (Table 3.29).

C. Summary

From the frequency distributions used to generate the preceding statistics, a picture of the victim, perpetrator and abuse/neglect situation emerges which is fairly consistent across the three sites. The victims were about 75 years in age, more likely to be female than male and inhabiting households with family members, including, a sizable proportion living with husbands, whereas the perpetrators tended to be younger and male, sons rather than husbands. Psychological abuse appeared to be most common, often accompanying other forms of abuse/neglect. An analysis of the manifestations of abuse indicates that physical abuse most often was characterized by bruises and welts; psychological abuse, by verbal assault and intimidation; and neglect by lack of support and companionship. For a sizable proportion of victims in all sites, the situation was considered to be very threatening or life threatening. When asked the reason for such behavior, the perpetrators tended to deny that the situation existed. The case workers pointed to the presence of mental problems in at least one third of the abusers and a history of mental illness and alcohol abuse in an even larger percentage.

TABLE 3.28 LEGAL INTERVENTION BY THE MODEL PROJECTS

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Legal action is appropriate for particular case:			
Yes	19(32.2)	15(11.2)	51(38.1)
Not at all	14(23.7)	62(46.3)	19(4.2)
Not sure at this time	26(44.1)	57(42.5)	64(47.8)
No answer	-	1	-
b) If YES, action that might be appropriate:			
Order of protection	11(35.5)	19(37.3)	17(29.8)
Conservatorship	6(19.4)	6(11.8)	2(3.5)
Involuntary commitment (psychiatric)	6(19.4)	8(15.7)	16(28.1)
Short term involuntary protective removal	-	10(19.6)	7(12.3)
Competency judgment	4(12.9)	3(5.9)	4(7.0)
Representative or protective payee	5(16.1)	13(23.5)	2(3.5)
Criminal action	2(6.5)	6(11.8)	15(26.3)
Family court	-	8(15.7)	3(5.3)
Other	12(38.7)	7(13.7)	20(35.1)
No answer	28	84	77
c) Above legal action has been initiated or will be initiated:			
Yes	13(24.1)	10(7.8)	2(10.0)
No	41(75.9)	119(92.2)	18(90.0)
No answer	5	6	114

TABLE 3.28 LEGAL INTERVENTION BY THE MODEL PROJECTS (cont.)

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
d) If YES, the following action was initiated*:			
Order of protection	5(31.3)	2(20.0)	8(26.7)
Conservatorship	-	1(10.0)	2(6.7)
Involuntary commitment	1(5.3)	2(20.0)	3(10.0)
Short term involuntary protective removal	-	1(10.0)	1(3.3)
Competency judgment	2(12.5)	-	1(3.3)
Representative or protective payee	2(12.5)	1(10.0)	-
Criminal action	1(6.3)	2(20.0)	6(20.0)
Family court	-	3(30.0)	1(3.3)
Other	-	3(30.0)	14(46.7)
No answer	43	125	104
e) Mandated reporting legislation would have helped effect earlier or more effective case intervention:			
Yes	8(17.4)	16(12.4)	-
No	38(82.6)	112(86.8)	-
No answer**	13	7	-
f) Short term involuntary protective removal legislation would have made earlier or more effective intervention a possibility:			
Yes	2(4.3)	23(18.0)	27(26.5)
No	45(95.7)	105(82.0)	75(73.5)
No answer	12	7	32

*Columns do not add to 100 percent because of multiple responses

**Mandatory reporting legislation already in effect in Rhode Island.

TABLE 3.29 DEGREE OF HINDRANCE OF BARRIERS TO DELIVERY OF APPROPRIATE SERVICES

	Not Hindered	Hindered A Little	Hindered A Lot	N/A
	# %	# %	# %	#
Worcester (n=59)				
Availability of services	21(61.8)	9(26.5)	4(11.8)	25
Bureaucratic red-tape	17(68.0)	4(16.0)	4(16.0)	34
Coordination of agencies	34(85.0)	3(7.5)	3(7.5)	19
Coordination of services	33(89.2)	2(5.4)	2(5.4)	22
Lack of protective services	15(78.9)	1(5.3)	3(15.8)	41
Lack of respite care	11(52.4)	6(28.6)	4(19.0)	38
Lack of support groups-caretakers	11(68.8)	5(31.2)	-	43
Legal implications of intervention	15(51.7)	7(21.6)	6(20.7)	31
Non-reimbursement for services	18(78.3)	2(8.7)	3(13.0)	36
Number of agencies involved	31(91.2)	1(2.9)	2(5.9)	25
Receptivity of abused to help	20(36.4)	18(32.7)	17(30.9)	4
Receptivity of abuser to help	6(13.0)	10(21.7)	30(65.2)	13
Other	2(25.0)	-	6(75.0)	51
Syracuse (n=135)				
Availability of services	35(30.4)	59(51.3)	21(18.3)	20
Bureaucratic red-tape	33(64.7)	8(15.7)	10(19.6)	84
Coordination of agencies	68(65.4)	31(29.8)	5(4.8)	31
Coordination of services	64(61.5)	32(30.8)	8(7.7)	31
Lack of protective services	83(93.3)	5(5.6)	1(1.1)	46
Lack of respite care	58(70.7)	16(19.5)	8(9.8)	53
Lack of support groups-caretakers	42(48.8)	31(36.0)	13(15.1)	49
Legal implications of intervention	59(58.4)	32(31.7)	10(9.9)	34
Non-reimbursement for services	54(51.4)	16(15.2)	35(33.3)	30
Number of agencies involved	95(95.0)	3(3.0)	2(2.0)	35
Receptivity of abused to help	33(26.4)	45(36.0)	47(37.6)	10
Receptivity of abuser to help	14(11.1)	40(31.7)	75(57.1)	9
Other	17(73.9)	2(8.7)	4(17.4)	112
Rhode Island (n=134)				
Availability of services	56(75.7)	12(16.2)	6(8.1)	60
Bureaucratic red-tape	15(75.0)	3(15.0)	2(10.0)	114
Coordination of agencies	80(96.4)	3(3.6)	-	51
Coordination of services	82(97.6)	2(2.4)	.	50
Lack of protective services	13(31.7)	3(7.3)	25(61.0)	93
Lack of respite care	17(54.8)	10(32.3)	4(12.9)	103
Lack of support groups-caretakers	23(65.7)	8(22.9)	4(11.4)	99
Legal implications of intervention	24(50.0)	8(16.7)	16(3.3)	86
Non-reimbursement for services	17(100)	-	-	117
Number of agencies involved	82(100)	-	-	52
Receptivity of abused to help	25(24.3)	27(26.2)	51(49.5)	31
Receptivity of abuser to help	12(11.8)	12(11.8)	78(76.5)	32
Other	4(66.7)	-	2(33.3)	128

Generally, the victims were a dependent group. About half required supportive devices for mobility; a few were bedridden. A large majority in all sites had difficulties with the instrumental activities of daily living and were assessed to be in a poor emotional state. The degree of cognitive impairment varied among the sites from one quarter to more than one-half of the caseload, although a great majority of the victims were able to give consent. While this group was dependent on their caretakers or other family members for daily needs, financial management, transportation and companionship, they were relatively independent in terms of financial resources. For the perpetrators the situation was reversed. They were likely to be dependent on the victim for finances, but independent in other ways. For many of the victims, there was little contact with others besides the perpetrator or formal caregivers. A great deal of stress was evident in the lives of the perpetrators, including unrealistic expectations of the abused or demands for attention, changes in their own health status or financial problems.

Lack of data on perpetrators made it impossible to determine to what degree family violence was present in their earlier history. There was a small percentage of cases at all sites in which the perpetrators had been victimized as children or had been involved in other acts of violence in addition to elder abuse.

Referral patterns for the three Model Projects showed some variation with the Worcester Project receiving the largest proportion of the reports from private agencies, and Syracuse and Rhode Island, from public agencies, an indication of the different community response systems for dealing with protective service cases. In spite of the fact that mandatory reporting legislation was in effect in Rhode Island during the course of this study, the pattern of referrals of abuse situations to the Rhode Island Model Project was not very different from the other two Projects, except perhaps for a somewhat larger proportion of referrals directly from the victim and members of his/her family. Prior to admission to the Projects, a majority of the clients in all three sites were receiving health services. For a sizable portion of the cases the initial action on the part of the Projects was to contact other agencies, generally for medical services by the Worcester Project and for social services by Syracuse and Rhode Island, a variation which can be explained by the nature of the models.

In response to the question concerning legal action, there were some differences in opinion among the three projects as to whether legal action was appropriate, with Worcester assuming the most positive stance, and actually using legal interventions in a larger proportion of cases than the other two Projects. The most frequently found barrier to service delivery was "receptivity of the abuser and abused to help." Coordination of agencies and services presented little, if any, problem.

Although this analysis has provided answers as to "who" and "what," it has not helped very much in explaining "why" the situation existed and "how" it came about. One way of gaining more information about the problem is to compare the elder abuse clients with non-elder abuse clients. The next section presents the result of such an analysis. A more indepth examination of the cases by types of abuse will follow in the next chapter.

II. Case Comparisons

A. Methodology

This section of the evaluation is based on a comparison of abused/neglected and non-abused/non-neglected elders who were clients of the Worcester Model Project. During the course of the elder abuse Project, the Worcester Project Director asked the twenty five case managers working with the non-abused/non-neglected clients to select the first new case that a) was assigned to them during the period May - October 1981, and b) was still open at the end of a six month period. The process was repeated again the following year. Forty nine cases were selected (one case manager was unable to fulfill the assignment the second year) and became known as the "controls." The Case Assessment form designed for the abuse/neglect cases was modified for this sample by changing the terminology from "perpetrator" to "caretaker" and omitting all the questions pertaining to the type and manifestations of abuse and neglect (Appendix II, Exhibit 2). Unfortunately, because of the time constraints it was not possible for the data on these comparison cases to be recorded by the Project personnel so they were completed by each of the case managers for their clients. The Project Director did provide training for the case managers in using the form and then checked to determine whether the questions had been interpreted correctly. To find out whether the two independent groups could have been drawn from the same population, the chi-square test was used for the nominal data and the Mann-Whitney test, for the ordinal data.

B. Results

The four factors ("cycle of violence" was omitted because of insufficient data) which have been given varying emphasis in the literature as the bases of explanations for elderly abuse/neglect, are examined in terms of their relationship to the profiles of the 59 cases of elderly abuse/ neglect and 49 comparison cases of non-abused/neglected elderly. They include focus on: a) characteristics of the elders and their caretakers; b) the nature of dependency and exchange relationships; c) external stressors impacting on caretakers and elders; and d) the degree of social isolation of both parties. Since it was not possible to match cases and "controls" in the selection process, the decision to move ahead with the comparison study was made on the basis of the similarities in the two samples in terms of basic demographic data. As will be shown shortly, the two groups were found not to differ significantly with respect to age, sex, marital status or income.

Characteristics of the Elders

There were no significant differences between the abuse/neglect cases and comparison in age, sex, religion and of the elderly clients (Table 3.30). However, the emotional and mental health of the victims were significantly worse than the non-abused/neglected elders (Table 3.31). The emotional status of the elders was considered "poor" in 58.8 percent of the abuse/neglect cases and in 8.5 percent of the controls. Conversely, the emotional state of the maltreated elderly clients was considered "excellent" in none of the cases compared to 25.5 percent of the controls; also the self-esteem of the elderly clients was rated "very high" in none of the cases, compared to 23.9 percent of the controls. The self-esteem of 44.5 percent of the abused/ neglected elders was seen as "moderately" or "very" low, while only 21.8 percent of the non-abused/neglected elders were given the same rating. Sixty-one (61.0) percent of the elderly cases had suffered a recent decline in mental health prior to their being abused or neglected. In the comparison group, 6.4 percent of the elderly clients had experienced such a decline. A recent increase in provocative behavior by elderly clients towards their caretakers, was found in 37.3 percent of the abuse/neglect cases and 2.1 percent of comparison group.

Characteristics of the Caretakers

Before reporting the results of the analyses of abused and non-abused clients, it should be pointed out that there were only twenty-one caretakers involved with the comparison group of forty-nine clients while a caretaker (perpetrator) was identified for every abused/ neglected elder (by definition). The remaining twenty-eight lived alone without a caretaker. Perhaps, the most obvious difference between the two groups of clients, therefore, was in their household composition. Whereas only one-eighth of the abused/neglected clients lived alone (13.6 percent) almost three-quarters of the non-abused group (71.4 percent) were in one-person households.

According to Table 3.32, there was a statistically significant difference ($p < .05$) between the gender composition of caretakers who were perpetrators of abuse or neglect (cases) and those caretakers who were associated with the controls. A significantly higher proportion of caretakers responsible for acts of abuse and neglect were men (71.2 percent) when compared to the latter group (23.8 percent). There were no significant differences in the age or religious characteristics of caretakers between the cases and comparison group nor in health status (Table 3.33).

As can be seen in Table 3.34, a significantly higher percentage of caretakers in abuse/neglect cases had a history of mental or emotional illness and had suffered a decline in their mental health prior to perpetrators. At the same time, alcohol abuse occurred also, in significantly higher proportions in caretakers involved in elderly abuse and neglect. Over forty (40.7) percent of the caretakers in the case had a history of emotional or mental illness. This compares to 5.3 percent of the control group. Nearly forty-six (45.8) percent of the perpetrators had experienced a decline in their mental health prior to the perpetra-

TABLE 3.30 SOCIODEMOGRAPHIC CHARACTERISTICS OF ELDERS

Sociodemographic Characteristics	Cases		Statistic	Controls	
	#	%		#	%
a) Age:					
<60	1	1.7		0	0.0
60-64	10	16.9		7	14.3
65-69	7	11.9	Z=-.30	5	10.2
70-74	6	10.2	p=.76	4	8.2
75-79	11	18.6		14	28.6
80-84	14	23.7		12	24.5
>85	10	16.9		7	14.3
	59	100.0		49	100.0
b) Sex:					
Male	12	20.3	X^2=.07	11	22.4
Female	47	79.7	p=.79	38	77.6
	59	100.0		49	100.0
c) Religion:					
Catholic	29	82.9		21	77.8
Protestant	5	14.3	X^2=7.03	1	3.7
Jewish	0	0.0	p=.071	4	14.8
Other	1	2.9		1	3.7
	35	100.		27	100.0
d) Income:					
<4,999	33	61.1		26	55.3
5,000-9,999	18	33.3	Z=-.33	21	44.7
>10,000	3	5.6	p=.74	0	0.0
	54	100.0		47	100.0
e) Household Composition					
Lives alone	8	13.6	X^2=36.41	35	71.4
Lives with others	51	86.4	p=.0001	14	28.6
	59	100.0		49	100.0

TABLE 3.31 EMOTIONAL/MENTAL STATUS OF ELDERS

Mental/Emotional Health	Cases		Statistic	Controls	
	#	%		#	%
a) Assessed emotional state:					
Excellent	0	0.0		12	25.5
Good	21	41.2	Z=-5.77	31	66.0
Poor	30	58.8	p=.0001	4	8.5
	51	100.0		47	100.0
b) Assessed self-esteem:					
Very low	2	5.6		1	2.2
Moderately low	14	38.9	Z=3.11	9	19.6
Moderately high	20	55.6	p=.002	25	54.3
Very high	0	0.0		11	23.9
	36	100.0		46	100.0
c) Current mental health status:					
i) Mental health changes:					
A recent decline	36	61.0	X^2=33.58	3	6.4
No recent decline	23	39.0	p=.0001	44	93.6
	59	100.0		47	100.0
ii) Provocative behavior:					
A recent increase	22	37.3	X^2=19.04	1	2.1
No recent increase	37	62.7	p=.0001	46	97.9
	59	100.0		47	100.0

TABLE 3.32 SOCIODEMOGRAPHIC CHARACTERISTICS OF CARETAKERS

Sociodemographic Characteristics	Cases		Statistic	Controls	
	#	%		#	%
a) Age:					
<30	7	11.9		0	0.0
30-49	16	27.1		7	33.3
50-59	10	16.9	$z=-.51$	3	14.3
60-69	7	11.9	$p=.607$	6	28.6
70-79	8	13.6		3	14.3
>80	11	18.6		2	9.5
	59	100.0		21	100.0
b) Sex:					
Male	42	71.2	$X^2=14.34$	5	23.8
Female	17	28.8	$p=.0002$	16	76.2
	59	100.0		21	100.0
c) Religion:					
Catholic	20	80.0		8	80.0
Protestant	4	16.0	$X^2=3.08$	1	10.0
Jewish	0	0.0	$p=.380$	1	10.0
Other	1	4.0		0	0.0
	25	100.0		10	100.0
d) Caretaker lives with client					
Yes	49	83.1	$X^2=12.55$	9	42.9
No	10	16.9	$p=.0004$	12	57.1
Not Appropriate	-	0		28	-
	59	100.0		49	100.0

TABLE 3.33 HEALTH STATUS OF CARETAKERS

Health Status	Cases		Statistic	Controls	
	#	%		#	%
a) Long term health problem:					
No	43	72.9	X^2=1.00	16	84.2
Yes	16	27.1	p=.317	3	15.8
	59	100.0		13	100.0
b) Short term health problem:					
No	48	81.4	X^2=.68	17	89.5
Yes	11	18.6	p=.409	2	10.5
	59	100.0		19	100.0
c) Recent decline in health:					
Yes	23	39.0	X^2=2.40	16	80.0
No	36	61.0	p=.12	4	20.0
	59	100.0		20	100.0

TABLE 3.34 EMOTIONAL/MENTAL STATUS OF CARETAKERS

Emotional/Mental Status	Cases		Statistic	Controls	
	#	%		#	%
a) History of mental health problems:					
No	35	59.3	X^2=8.28	18	94.7
Yes	24	40.7	p=.004	1	5.3
	59	100.0		19	100.0
b) Substance abuse history:					
i) Problems with alcohol abuse					
No	38	64.4	X^2=8.85	19	100.0
Yes	20	33.3	p=.003	0	0.0
Yes, suspected	1	1.7		0	0.0
	59	100.0		19	10.0
ii) Problems with drug abuse:					
No	55	93.2	X^2=1.36	19	100.0
Yes	4	6.8	p=.003	0	0.0
	59	100.0		19	100.0
c) Current mental health status:					
A recent decline	27	45.8	X^2=10.85	1	5.0
No recent decline	32	54.2	p=.001	19	95.0
	59	100.0		20	100.0
d) Provocative behavior:					
A recent increase	8	13.8	X^2=1.13	1	5.0
No recent increase	50	86.2	p=.289	19	95.0
	58	100.0		20	100.0

tion, compared to 5.0 percent of the control group. The percentage of alcohol abuse was 33.9 percent among the perpetrators and none for caretakers in the comparison group. There were no significant differences between controls and cases with respect to drug abuses and behavior provocative to the elder.

Dependency and Exchange Relationships

Health status of the elders. There were no significant differences between abused/neglected elderly and non-abused/neglected elderly with respect to the numbers of impairments requiring attention, nor the numbers of prescribed medications (Table 3.35). A significant proportion of elders in the cases, however, had experienced a recent loss in weight. In the cases, 19.4 percent of the elderly clients had recently last weight; in the non-abuse sample the comparable figure was 4.3 percent. Not surprisingly, elders in the comparison group were said to have better eating habits in a significantly higher proportion. Fifty eight (58.1 percent) of the abused/neglected elders were said to be eating "well," compared to 85.7 percent of the non-abused/neglected elderly. In addition, a significant percentage of the maltreated elderly were reported to have experienced a recent decline in physical health (81.4 percent) prior to an act of abuse or neglect. A decline in the physical health was found in 21.3 percent of the non-victimized elders.

Cognitive functioning of the elders. Table 3.36 shows the comparative cognitive functioning of elders in the two groups, with respect to orientation, memory and ability to provide consent. Generally, elders who were abused and neglected had significantly lower cognitive functioning when compared to the non-abused group except in the area of remote memory. In the abuse project cases, the percentage of elders with ongoing problems in orientation (person, place and time) and memory (immediate and recent) ranged from between 11.1 percent to 17.8 percent. This compares to rate of between 0.0 percent and 6.4 percent for elders in the non-abuse group. Similarly, the percentages of cases without orientation and memory problems ranged from 60.0 percent to 73.6 percent, whereas, in the comparison group, the range was between 73.5 percent and 91.8 percent. Elderly victims of abuse/neglect were able to provide consent in a significantly lower percentage (81.6 percent) when compared to elders in the non-victimized group (95.8 percent).

Instrumental acbivities of daily living. It is apparent from Table 3.37, that elderly clients who were abused or neglected had problems with personal care, mobility, meal preparation, safety of property, and management of personal affairs, in significantly higher proportions than elders in the comparison group but were not significantly different with respect to their shopping and transportation. For one activity, household management, the "controls" in the comparison group had a significantly higher percentage (89.8 percent) of problems, compared to the abuse/neglect cases (72.9 percent). Among the elderly victims 72.4 percent needed help for personal care; 66.1 percent, 74.6 percent, meal preparation; 50.0 percent for safety of property; and 76.3 percent, management of personal affairs. In the comparison group, the cor-

TABLE 3.35 HEALTH STATUS OF ELDERS

Health Status	Cases		Statistic	Controls	
	#	%		#	%
a) Number of impairments requiring attention:					
0	3	5.2		1	2.1
1	6	10.3		3	6.3
2	15	25.9	$X^2=3.48$	10	20.8
3	18	31.0	$p=.747$	16	33.3
4	10	17.2		12	25.0
5	5	8.6		6	12.5
6	1	1.7		0	0.0
	58	100.0		48	100.0
b) Number of medications:					
0	15	32.6		5	10.6
1	5	10.9		7	14.9
2	5	10.9		10	21.3
3	7	15.2	$X^2=11.38$	11	23.4
4	8	17.4	$p=.181$	5	10.6
5	3	6.5		4	8.5
6	2	4.3		4	8.5
7	0	0.0		1	2.1
8	1	2.2		0	0.0
	46	100.0		47	100.0
c) Weight change:					
Gained weight	0	0.0		2	4.3
Lost weight	7	19.4	$X^2=6.03$	2	4.3
No change	29	80.6	$p=.049$	42	91.3
	36	100.0		46	100.0
d) Eating habits:					
Eating well	25	58.1	$X^2=8.80$	42	85.7
Not eating well	18	41.9	$p=.003$	7	14.3
	43	100.0		49	100.0
e) Changes in health status:					
A recent decline	48	81.4	$X^2=38.11$	10	21.3
No recent decline	11	18.6	$p=0.0001$	37	78.7
	59	100.0		47	100.0

TABLE 3.36 COGNITIVE STATUS OF ELDERLY CLIENTS

Cognitive Status	Cases		Statistic	Controls	
	#	%		#	%
a) Orientation to person:					
On-going problem	6	11.1		1	2.0
Intermittent problem	13	24.1	$X^2$7.72	5	10.2
No problem	35	64.8	p=.021	43	87.8
	54	100.0		49	100.0
b) Orientation to place:					
Ongoing problem	6	11.3		1	2.0
Intermittent problem	8	15.1	X^2=6.13	3	6.1
No problem	39	73.6	p=.047	45	91.8
	53	100.		49	100.0
c) Orientation to time:					
Ongoing problem	8	15.1		0	0.0
Intermittent problem	10	18.9	X^2=9.98	5	10.6
No problem	35	66.0	p=.007	42	89.4
	53	100.0		47	100.0
d) Immediate memory:					
In-going problem	8	16.7		0	0.0
Intermittent problem	6	12.5	X^2=9.33	10	20.4
No problem	34	70.8	p=.009	39	79.6
	48	100.0		49	100.0
e) Recent memory:					
On-going problem	8	17.8		1	2.0
Intermittent problem	10	22.2	X^2=6.75	12	24.5
No problem	27	60.0	p=.034	36	73.5
	45	100.0		49	100.0
f) Remove memory:					
On-going problem	5	13.5		3	6.4
Intermittent problem	7	18.9	X^2=1.38	8	17.0
No problem	25	67.6	p=.502	36	76.6
	37	100.0		47	100.0
g) Ability to consent:					
Can give consent	40	81.6	X^2=4.86	46	95.8
Cannot give consent	9	18.4	p=.027	2	4.2
	49	100.0		48	100.0

TABLE 3.37 ELDERS' PROBLEMS WITH INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Instrumental Activities	Cases		Statistic	Controls	
	#	%		#	%
a) Personal care:					
Problem	42	72.4	X^2=16.92	16	32.7
No problem	16	27.6	p=.0001	33	67.3
	58	100.0		49	100.0
b) Mobility:					
Problem	39	66.1	X^2=9.04	19	38.8
No problem	20	33.9	p=.005	30	61.2
	59	100.0		49	100.0
c) Meal preparation:					
Problem	44	74.6	X^2=5.43	26	53.1
No problem	15	25.4	p=.020	23	46.9
	59	100.0		49	100.0
d) Safety of property:					
Problem	29	50.0	X^2=10.04	10	20.4
No Problem	29	50.0	p=.002	39	79.6
	58	100.0		49	100.0
e) Management of personal affairs:					
Problem	45	76.3	X^2=17.22	18	36.7
No problem	14	23.7	p=.001	31	63.3
	59	100.0		49	100.0
f) Shopping:					
Problem	39	66.1	X^2=2.52	25	51.0
No problem	20	33.9	p=.112	24	49.0
	59	100.0		49	100.0
g) Transportation:					
Problem	43	72.9	X^2=.005	36	73.5
No problem	16	27.1	p=.95	13	26.5
	59	100.0		49	100.0
h) Household management:					
Problem	43	72.9	X^2=4.89	44	89.8
No problem	16	27.1	p=.027	5	10.2
	59	100.0		49	100.0

responding percentages were 32.7 percent, personal care; 38.8 percent mobility; 53.1 percent, meal preparation; 20.4 percent, safety of property; and 36.7 percent, management of personal affairs.

Dependency status. As shown in Table 3.38, there were no significant differences between the abuse cases and comparison group with respect to the degree of dependency of elder clients for financial resources, financial management, companionship, transportation, daily needs (e.g., medication and meals) and property maintenance, although abused/neglected elders were reported to have experienced recent increased dependency needs in a significantly higher proportion, (61.0 percent) compared to only 4.3 percent of the non-abused clients. A significantly higher percentage of caretakers involved in perpetrations, however, were dependent on the elder for their financial needs (Table 3.39). Just over twenty-five (25.6) percent of the former were financially independent compared to 63.2 percent of the latter. Nearly forty-two (41.9) percent of the abusers were "very dependent" on the elder for finances, compared to 15.8 percent of the caretakers in non-abuse cases. There were no significant differences between the two groups with respect to their companionship dependencies, nor the degree to which both sets of caretakers had become increasingly dependent in recent times.

Relationship dynamics. The data in Table 3.40 indicate the presence of a significantly greater degree of interpersonal pathology between the elder and his/her caretaker in abuse/neglect cases, compared to the non-abuse cases. The relationship between elders and caretakers was considered "poor" in 77.2 percent of the cases, and 4.8 percent of the "controls." In 1.8 percent of the abuse cases the relationship was reported to be "excellent," compared to 52.4 percent of the non-abuse cases. Caretakers were said to have unrealistic expectations of their elderly counterparts in 67.9 percent of the abuse/neglect situations while in the comparison group, unrealistic expectations by caretakers were reported at a rate of 5.6 percent.

External Stress

According to Table 3.41 which shows the percentages of externally induced, potential stressors on caretakers for cases and controls, elders in abuse/neglect situations were a significantly greater source of stress to the caretaker, compared to the non-abuse group. Perpetrators too, were potentially stressed, at significantly higher rates, by recent changes in their family relationships and living arrangements. There were no significant differences between the two groups with respect to the following, potentially stressful events: recent loss of spouse through death or divorce separation; recent birth of a child; prior suicide attempts; long or short term financial problems. The degree of stress imposed by elders on caretakers was considered "a lot" in 66.7 percent of the cases, compared to 23.5 percent of the comparison sample. No stress was encountered in 19.4 percent of the abuse cases and 47.1 percent of the non-abuse cases. Over sixty (60.3) percent of perpetrators had experienced a recent change in their family relationships prior to an act of abuse or neglect, compared to 15.0 percent of

TABLE 3.38 DEPENDENCY STATUS OF ELDERS

Dependency Status	Cases		Statistic	Controls	
	#	%		#	%
a) Financial resources:					
Independent	29	52.7		9	50.0
Slightly dependent	15	27.3	Z=-.22	5	27.8
Very dependent	11	20.0	p= 82	4	22.2
	55	100.0		18	100.0
b) Financial management:					
Independent	18	32.1		6	31.6
Slightly dependent	2	3.6	Z=-.84	4	21.1
Very dependent	36	64.3	p=.40	9	47.4
	56	100.0		19	100.0
c) Companionship:					
Independent	12	20.7		2	10.5
Slightly dependent	10	17.2	Z-.04	6	31.6
Very dependent	36	62.1	p=.97	11	57.9
	58	100.0		19	100.0
d) Transportation:					
Independent	21	38.9		4	21.1
Slightly dependent	4	7.4	2=1.27	2	10.5
Very dependent	29	53.7	p=.20	13	68.4
	54	100.0		19	100.0
e) Daily needs:					
Independent	22	37.9		7	41.2
Slightly dependent	5	8.6	Z=-.38	2	11.8
Very dependent	31	53.4	p=.0	8	47.1
	58	100.0		17	100.0
f) Property maintenance:					
Independent	19	34.5		6	40.0
Slightly dependent	9	16.4	Z=-.84	4	26.7
Very dependent	27	49.1	p=.40	5	33.3
	55	100.0		15	100.0
g) Overall dependency:					
A recent increase	36	61.0	X^2=36.65	2	4.3
No recent increase	23	39.0	p=.0001	45	95.7
	59	100.0		47	100.0

TABLE 3.39 DEPENDENCY STATUS OF CARETAKERS

Dependency Status	Cases		Statistic	Controls	
	#	%		#	%
a) General increase in dependency needs:					
Yes	7	12.1	X^2=.81	1	5.0
No	51	87.9	p=.369	19	95.0
	58	100.0		20	100.0
b) Financial needs:					
Independent	11	25.6		12	63.2
Slightly dependent	14	32.6	Z=-2.73	4	21.1
Very dependent	18	41.9	p=.006	3	15.8
	43	100.0		19	100.0
c) Companionship needs:					
Independent	1	8.3		0	0.0
Slightly dependent	4	33.3	Z=-.10	1	50.0
Very dependent	7	58.3	p=.917	1	50.0
	12	100.0		2	100.0

TABLE 3.40 INTERPERSONAL DYNAMICS BETWEEN ELDER AND CARETAKER

Relationship Dynamics	Cases		Statistic	Controls	
	#	%		#	%
a) Assessed quality of relationship:					
Poor	44	77.2		1	4.8
Good	12	21.1	$Z=-2.17$	9	42.9
Excellent	1	1.8	$p=.029$	11	52.4
	57	100.0		21	100.0
b) Caretaker expectations:					
Caretaker has unrealistic expectations of elder	19	67.9	$X^2=17.31$ $p=.0001$	1	5.6
Caretaker does not have unrealistic expectations of elder	9	32.1		17	94.4
	28	100.0		18	100.0

TABLE 3.41 EXTERNAL STRESSORS ON CARETAKERS

External Stressors	Cases		Statistic	Controls	
	#	%		#	%
a) Degree of stress elder imposes on caretaker:					
A lot	24	66.7		4	23.5
A little	5	13.9	Z=-2.82	5	29.4
Not at all	7	19.4	p=.005	8	47.1
	36	100.0		17	100.0
b) Specific stresses on caretaker:					
i) Recent loss of spouse through death:					
No	56	94.9	X^2=1.00	19	100.0
Yes	3	5.1	p=.316	0	0.0
	59	100.0		19	100.0
ii) Recent loss of spouse through divorce/ separation:					
No	52	88.1	X^2=2.48	19	100.0
Yes	7	11.9	p=.116	0	0.0
	59	100.0		19	100.0
iii) Recent birth of child:					
No	58	98.3	X^2=.73	18	94.7
Yes	1	1.7	p=.116	1	5.3
	59	100.0		19	100.0
iv) Past suicide attempt:					
No	55	93.2	X^2=1.36	19	100.0
Yes	4	6.8	p=.244	0	0.0
	59	100.0		19	100.0
v) Long term financial problems:					
No	49	83.1	X^2=.014	16	84.2
Yes	10	16.9	p=.906	3	15.8
	59	100.0		19	100.0

TABLE 3.41 EXTERNAL STRESSORS ON CARETAKERS (cont'd)

External Stressors	Cases		Statistic	Controls	
vi) Recent financial problems:					
No	51	86.4	X^2=12	17	89.5
Yes	8	13.6	p=.731	2	10.5
	59	100.0		19	100.0
vii) Recent change in family relationships:					
No	35	39.7	X^2=4.07	17	85.0
Yes	23	60.3	p=.044	3	15.0
	58	100.0		20	100.0
viii) Recent change in living arrangements:					
No	34	58.6	X^2=11.95	20	100.0
Yes	24	41.4	p=.0005	0	0.0
	58	100.0		20	100.0

the caretakers in the non-abuse situations. Over forty-one (41.4) percent of the former had also experienced a recent change in their living arrangements compared to none of the latter.

Similarly, elderly clients in abuse/neglect situations experienced potentially stressful life changes, related to their families and living situations, at significantly higher rates than the elderly in the comparison group. There was no significant difference in the rates at which the two groups had experienced changes in their financial or job status. The percentages of elders who had experienced a recent change in their family relationships (e.g., death of a spouse) were 39.0 percent for the abuse cases and 4.3 percent for the non-abuse cases. Thirty-seven (37.3) percent of the mistreated elderly had experienced a recent change in their living situation, compared to 10.6 percent of the elderly who were not mistreated (Table 3.42).

Social Isolation

An examination of the living situation and social network of elderly clients (Table 3.43) indicates that those who are abused or neglected, unlike their non-abused counterparts, tend to dwell with others, particularly their caretaker, and have fewer social contacts because of recent losses. Eighty-six (86.4) percent of the abused elders live with others, compared to 29.2 percent of the "controls." Eighty-three (83.1) percent of the abused/neglected elderly reside with their caretaker, compared to 42.9 percent of those who are not abused or neglected. Despite this tendency of non-abused elderly to live alone, the comparison group has a signficantly more extensive social network. Almost 19 (18.9) percent of the abused elderly have no social contacts, whereas only 6.1 percent of the controls are without contacts. The most frequent number of contacts for the victimized elders is two contacts, and for the comparison group, it is five. A factor in the differences in the social networks of the two groups is the significantly higher attrition rate for the cases. Over 35 (35.6) percent of this group have suffered recent losses in their support system, compared to 4.3 percent in the comparison group. (Table 3.44)

Concerning other factors related to social isolation, there were no significant differences between the two groups of elders with respect to marital status, frequency of social contacts, church or club affiliations, or the availability of an emergency contact nor were there any significant differences between caretakers in the study and comparison groups with respect to the availability of familial support, the presence of an emergency contact, and the stability of support systems (Table 3.45).

C. Discussion

An analysis of the data indicates that all four factors under study play a role in cases of elderly abuse/neglect: the characteristics of the elder and caretaker, dependency and exchange relationships, external stresses and social isolation. Violence against the elderly is more likely to occur if men are the caretakers, particularly if the male caretaker has a history of mental health problems, including recent

TABLE 3.42 EXTERNAL STRESSORS ON ELDERS

External Stressors	Cases		Statistic	Controls	
	#	%		#	%
a) Family relationship:					
A recent change	23	39.0	X^2=17.51	2	4.3
No recent change	36	61.0	p=.0001	47	95.7
	59	100.0		49	100.0
b) Financial/job status:					
A recent change	5	8.5	X^2=.76	2	4.3
No recent change	54	91.5	p=.385	45	95.7
	59	100.0		47	100.0
c) Living situation:					
A recent change	22	33.3	X^2=9.79	5	10.6
No recent change	37	62.7	p=.002	42	89.4
	59	100.0		47	100.0

TABLE 3.43 ELDERS' LIVING AND MARITAL STATUS

Support Systems	Cases		Statistic	Controls	
	#	%		#	%
a) Living situation:					
Elder lives alone	8	13.6		34	70.8
Elder lives with others	51	86.4	X^2=36.41 p=.0001	14	29.2
	49	100.0		48	100.0
Elder lives with caretakers	49	83.1	X^2=12.55	9	42.9
Elder does not live with caretaker	10	16.9	p=.0004	12	57.1
	59	100.0		21	100.0
b) Marital status:					
Single	7	12.1		7	14.3
Married	21	36.2	X^2=1.15	13	26.5
Widowed	26	44.8	p=.76	25	51.0
Divorced/separated	4	6.9		4	8.2
	58	100.0		49	100.0

TABLE 3.4.4 ELDERS' SOCIAL NETWORK

Support Systems	Cases		Statistic	Controls	
	#	%		#	%
a) Social contacts:					
i) Number of contacts:					
One	8	13.8		6	12.2
Two	15	25.9		8	16.3
Three	13	22.4	Z=-2.41	9	18.4
Four	8	13.8	p=.016	8	16.3
Five	3	5.2		15	30.6
None	11	18.9		3	6.1
	58	100.0		49	100.0
ii) Frequency of contact:					
Daily	11	21.2	Z=-1.70	17	34.7
Weekly	20	38.5	Z=01.70	24	49.0
Monthly	11	21.2	p=.089	5	10.2
None	10	19.2		3	6.1
	52	100.0		49	100.0
iii) Contact with church or clubs:					
Yes	8	13.8	X^2=1.69	3	6.1
No	50	86.2	p-.193	46	93.9
	58	100.0		49	100.0
b) Dynamics of contacts:					
A recent loss of supports/contacts	21	35.6	X^2-15.12	2	4.3
No recent loss of supports/contacts	38	64.6	p=.0001	45	95.7
	59	100.0		47	100.0
c) Emergency contact:					
Has an emergency contact	42	93.3		48	100.0
Has no emergency contact	2	4.4	X^2=3.31	0	0.0
Unable to use telephone	1	2.2	p=.191	0	0.0
	45	100.0		48	100.0

TABLE 3.45 CARETAKERS' SOCIAL NETWORK

Support System	Cases		Statistic	Controls	
	#	%		#	%
a) Familial support system:					
Family members available for support	34	77.3	X^2=1.28 p=.258	17	89.5
No family members available for support	10	22.7		2	10.5
	44	100.0		19	100.0
b) Emergency contact:					
Has an emergency contact	35	89.7	X^2=1.88	17	100.0
Has no emergency contact	4	10.3	p=.171	0	0.0
	39	100.0		17	100.0
c) Dynamics of support system:					
A recent loss of support	10	17.2	X^2=1.84	1	5.0
No recent loss of support	48	82.8	p=.17	19	95.0
	58	100.0		20	100.0

deterioration in mental health, and when alcohol abuse is present. Elders who are abused or neglected are more likely to have emotional and psychological difficulties themselves. They tend to have low self-esteem and be in poor emotional health, with evidence of recent deterioration in their mental health. Their psychological and emotional difficulties are reflected in a tendency for them to be provocative in their behavior towards caretakers.

On the other hand, elders who are abused or neglected in this study are not more physically impaired than non-abused elders, with respect to the number of impairments requiring attention or number of medications required for treating physical disabilities. They do tend, however, to have experienced a recent decline in their physical health prior to the report to the agencies and to have lost weight. In stark contrast, abused/neglected elders are more likely to have problems with cognitive functioning, evidenced by orientation and memory impairments and the ability to give consent amd to have significant problems with instrumental activities of daily living, related to personal care, mobility, meal preparation, safety of property and management of personal affairs. Surprisingly, in some ways, given the cognitive and functional impairments of abused/neglected elders, they are not seen as more dependent than the control group, with respect to financial resources and management, companionship, transportation, daily needs, nor property maintenance. A recent, significant increase in their dependency status, was, however, indicated.

Caretakers involved in maltreatment are not more physically impaired than caretakers in the comparison group. They tend to be, however, more financially dependent on the elderly person than is the case for the control group. Pathologies in the exchange relationship between perpetrators and elders are indicated by the data. Previous research has shown that the dependency needs of elders are likely to cause a disparity in the exchange of perceived rewards between the two parties. That is to say, the perceived costs of the relationship are likely to be seen as outweighing rewards as the dependency needs of the elder increase. Data from this study indicate that any perceived disparities in the exchange relationship are more likely to be related to the psychological status and interpersonal dynamics of both parties rather than the dependency requirements of the elder. Certainly some pathology in the relationship between perpetrators and elders, and associated values assigned to exchanges, are suggested by the data. Relationships between caretakers and elders in abuse/neglect situations are more likely to be assessed as "poor," evidenced in part, by the unrealistic expectations of caretakers and the provocative behavior of clients. Such pathology in the exchanges between perpetrators and caretakers is, however, predictable given the psychological difficulties of both parties.

Elders in abuse/neglect cases are seen as imposing a greater degree of stress on caretakers, when compared to the comparison group. The nature of this stress is probably more related to the pathology of the interpersonal relationship, given the tendency for these elders to be no more dependent for many of their needs. Both the elder and the caretaker in abuse/neglect cases are likely to be experiencing stresses related to intertwined changes in family and living situations, which are reflected by both parties assuming a common residence.

Because of recent losses in their social supports, elders in abuse/neglect cases have a depleted social network. They are more isolated, in an important way, than elders who are not abused or neglected. Elders in the control group, are, however, more likely to live alone. Given the fact they have an extensive social network, their living situation would seem to reflect a healthier independence, higher functional status and greater overall self-sufficiency. Finally, in this study, no significant differences were indicated concerning the degree of social support for caretakers in the abuse cases and control.

D. Conclusion

In trying to conceptualize the nature and dynamics of elderly abuse and neglect, especially in terms of the four factors under study, the following points seem clear.

- Individual attributes of perpetrators (largely men) and elders are an important underpinning to abuse/neglect cases. In particular, both parties have problems with their psychological and emotional health.
- Abused/neglected elderly do not appear to be more dependent than non-abused elderly for many needs. However, they do have significantly greater functional and cognitive impairments.
- A pathology in the exchange relationship between perpetrators and elders, related to interpersonal dynamics and personal emotional problems, seems to play an important role in cases of abuse/neglect. The interpersonal pathology is reflected in the provocative behavior of elders which probably underlies their being seen as a greater service of stress, and the unrealistic expectations of caretakers, which are in part related to a maintained financial dependency.
- Changes in the family and living situations of perpetrators and abused/neglected elderly lead to their lives becoming more intertwined, often in terms of the need to share a common residence.
- Abused/neglected elderly tend to be more isolated than elders who are not subject to perpetrators.

A later chapter offers another opportunity to compare abuse and non-abuse cases. Meanwhile, the following chapter is devoted to a more detailed study of each type of abuse.

CHAPTER FOUR

FACTORS RELATED TO ELDER ABUSE AND NEGLECT

In this chapter the four factors, which have been given varying emphasis in prior research as possible causal agents of elderly abuse and neglect, are examined in terms of their relationship to five discrete types of elderly abuse and neglect, i.e., physical, psychological and material abuse; active and passive neglect. They are: a) individual attributes of perpetrators and elders, related specifically, to their sociodemographic and psychological characteristics; b) the nature of dependency and exchange relationships; c) external stressors impacting on perpetrators and elders; and d) the degree of social isolation of both parties. The relationships of these factors and abuse/neglect types are reviewed, a) in the context of each of the three project sites, i.e., Worcester, Rhode Island and Syracuse, and b) with respect to commonalities among the findings at each site.

I. Worcester

A. Results

Characteristics of the Victims.

Neither the victim's age, sex or marital status was a significant factor in any type of abuse or neglect. The income level of the elderly victim was, however, related to cases of psychological abuse ($p < .05$). For those victims whose income was below $5,000 the rate of psychological abuse was 84.8 percent compared to 55.6 percent for those with incomes between $5,000-$10,000 (there were only three cases with greater incomes).

Characteristics of the Perpetrators.

The age of the perpetrator was a significant factor only in cases of material abuse. The percentage of material abuse in the group of perpetrators aged 30 years and under was 71.4 percent while for those between 30-49 years and 50-59 years it was 62.5 and 40.0 percent, respectively. On the other hand, for perpetrators over 80 years the percentage of material abuse was 18.2 percent, between 70-79 years, 0.0 percent; and 60-69 years, 28.6 percent (Table 4.1).

As indicated in Table 4.2, the psychological status of perpetrators, defined by recent changes in their mental health status and associated behavior, is significantly related to cases of physical abuse and passive neglect. If the perpetrators had experienced a recent decline in mental health, the rate of occurrence of physical abuse was 64.0 percent. Of those perpetrators whose mental health status had remained stable, the rate was 31.3 percent. With respect to passive neglect, it occurred at a rate of 56.3 percent in cases when the per-

TABLE 4.1 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY PERPETRATOR'S AGE* - WORCESTER

Age	All Cases	Physical Abuse	Psychological Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
< 30	7	57.1	85.7	71.4	0.0	14.3
30 - 49	16	37.5	62.5	62.5	18.8	50.0
50 - 59	10	60.0	90.0	40.0	20.0	40.0
60 - 69	7	28.6	71.4	28.6	28.6	71.4
70 - 79	7	57.1	62.5	0.0	25.0	37.5
> 80	10	40.0	72.7	18.2	0.0	36.4
		NS	NS	$p < .05$	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

TABLE 4.2 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY PERPETRATOR'S PSYCHOLOGICSL STATUS* - WORCESTER

Psychopathology Status	All Cases	Physical Abuse	Psychological Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Mental health changes:						
A recent decline	25	64.0	85.2	37.0	11.1	25.9
No recent decline	32	31.3	62.5	40.6	18.8	56.3
		p < .05	NS	NS	NS	p < .05
b) Provocative behavior:						
A recent increase	7	42.9	87.5	25.0	12.5	0.0
No recent increase	49	44.9	70.0	42.0	16.0	50.0
		NS	NS	NS	NS	p < .01

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

TABLE 4.3 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S MENTAL HEALTH STATUS* - WORCESTER

Mental Health Status	All Cases	Physical Abuse	Psychological Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Mental health changes:						
A recent decline	35	42.9	61.1	36.1	11.1	52.8
No recent decline	22	50.0	91.3	43.5	21.7	26.1
		NS	$p < .05$	NS	NS	$p < .05$
b) Assessed emotional behavior:						
Good	21	33.3	61.9	47.6	14.3	47.6
Poor	28	53.6	86.7	36.7	16.7	30.0
		NS	$p < .05$	NS	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

petrator's mental health status had remained stable, compared to 25.9 percent in situations where a decline had taken place. The percentage of passive neglect was 50.0 percent in cases where perpetrators had not evidenced signs of an increase in provocative behavior and 0.0 percent where such behavior had increased.

Dependency Status of the Victim

Health status. Although the physical health of elderly victims was not a significant factor in cases of abuse or neglect, the mental health and emotional status of victims, as perceived by caseworkers, were significant factors in cases of psychological abuse and passive neglect (Table 4.3). Significantly higher rates of psychological abuse were found in victims whose emotional status was poor (86.7 percent), albeit stable, than for those considered to be in "good" emotional health (61.9 percent). For those elders who had not suffered a recent decline in mental health, the rate of physical mistreatment was 91.3 percent, compared to 61.1 percent for those whose mental health had remained stable. The rate of passive neglect was higher (52.8 percent) for those victims whose mental health status had undergone a recent decline than for those (26.1 percent) whose mental health had remained stable.

Cognitive functioning. The degree of cognitive functioning of elderly victims was a significant factor in cases of psychological abuse and passive neglect (Table 4.4). In regard to of psychological abuse, cognitive functioning, as indicated by an elder's orientation, memory and consent status, was not considered a problem when its rate was highest. On the other hand, the rates of passive neglect were lowest for clients who were not considered to have problems with their level of cognitive functioning. For clients who had no problems with orientation or memory, the rates of psychological abuse ranged from between 84.0 percent to 92.6 percent in contrast to 40.0 percent to 50.0 percent for victims who had an on-going problem with the above cognitive processes. Of the elders who could give consent, 85 percent were psychologically abused compared to 33.3 percent for those elders who could not give consent. The range of passive neglect was between 18.5 percent and 30.8 percent for those victims who were without memory and orientation problems, from 60.0 to 85.7 percent for those with intermittent problems, and 50.0 to 75.0 percent for those with on-going problems.

Instrumental activities of daily living. As can be seen in Table 4.5, an elder victim's ability to perform instrumental activities of daily living is significantly related, in varying ways, to physical and psychological abuse and passive neglect. In general terms, elders who have a higher degree of functioning are more likely to be victims of physical and, in particular, psychological abuse, whereas those with problems performing instrumental activities are more apt to be victims of passive neglect. An elder's ability to manage household affairs was the only instrumental activity related to physical abuse with a higher percentage of physical abuse (73.3 percent) found in those elders without problems related to household management compared to those with such problems (35.7 percent). A significantly higher rate of psychological abuse was noted when elderly victims had no problem with their personal care, meal preparation and household management. The percentage of

TABLE 4.4 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S COGNITIVE STATUS - WORCESTER

Cognitive Status	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Orientation to person						
On-going problem	10	30.0	20.0	30.0	10.0	30.0
Intermittent problem	12	33.3	50.0	33.3	33.3	16.7
No problem	70	61.4	82.6	24.6	7.2	5.8
		NS	$p<.001$	NS	$p<.05$	$p<.05$
b) Orientation to place						
On-going problem	12	41.7	33.3	33.3	8.3	25.0
Intermittent problem	13	30.8	53.8	30.8	30.8	23.1
No problem	68	60.3	82.1	26.9	7.5	4.5
		NS	$p<.001$	NS	$p<.05$	$p<.05$
c) Orientation to time						
On-going problem	12	33.3	25.0	33.3	8.3	25.0
Intermittent problem	13	38.5	61.5	30.8	23.1	23.1
No problem	66	60.6	83.1	26.2	7.7	4.6
		NS	$p<.01$	NS	NS	$p<.01$
d) Immediate memory						
On-going problem	14	42.9	35.7	28.6	21.4	28.6
Intermittent problem	11	27.3	63.6	36.4	18.2	27.3
No problem	66	60.6	83.1	27.7	7.7	4.6
		NS	$p<.01$	NS	NS	$p<.01$
e) Recent memory						
On-going problem	14	50.0	35.7	28.6	21.4	21.4
Intermittent problem	13	15.4	69.2	38.5	15.4	30.8
No problem	63	61.9	82.3	27.4	8.1	4.8
		$p<.01$	$p<.01$	NS	NS	$p<.05$
f) Remote memory						
On-going problem	13	53.8	46.2	30.8	15.4	15.4
Intermittent problem	12	33.3	83.3	33.3	25.0	16.7
No problem	63	60.3	80.6	27.4	8.1	6.5
		NS	$p<.05$	NS	NS	NS
g) Ability to consent						
Yes	95	55.8	78.7	28.7	9.6	9.6
No	15	40.0	33.3	20.0	33.3	20.0
		NS	$p<.001$	NS	$p<.05$	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

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psychological abuse was greater than 90 percent when victims were without such problems compared to a rate of between 62.8 and 64.3 percent for those who had problems. Concerning passive neglect, however, rates ranged from 50.0 to 53.8 percent when victims had problems with personal care, meal preparation, shopping and household management compared to 12.5 percent to 20.0 percent when such problems did not exist. An additional item, an elder's need for a support device to assist mobility, was found to be related only to cases of active neglect ($p < .05$). Twenty-six (25.9) percent of elderly victims who required a supportive device were actively neglected, compared to 4.0 percent who did not require such a device.

Specific dependencies. Table 4.6 depicts the relationships between specific dependencies of elderly victims and each type of abuse and neglect. Significantly higher rates of psychological abuse were associated with victims who were more independent, and higher rates of passive neglect occurred with those who were more dependent, with respect to financial management, companionship, transportation, daily needs and property maintenance. Rates of psychological abuse ranged from between 84.2 and 95.5 percent for victims who were independent for these needs, compared to rates from 51.9 to 61.1 percent for those who were very dependent. On the other hand, the percentage of passive neglect was between 5.6 and 18.2 percent for victims who were independent on the same items, compared to a range of 52.5 and 61.3 percent for those who were very dependent. Concerning material abuse, its rate was significantly higher when victims were independent for transportation needs (52.4 percent) but lower (24.1 percent) for cases where they were very dependent.

Dependency Status of Perpetrators. The health status of perpetrators shown in Table 4.7 impacts only on cases of material abuse. The rate of material was significantly lower in those cases where victims had not experienced a decline in health prior to the abuse (17.4 percent), compared to cases where a recent decline in health status had been occurred (52.8 percent). Significantly higher rates of physical abuse were found in those cases where perpetrators had experienced an increase in overall dependency prior to the reporting of abuse/neglect but significantly lower rates of passive neglect were found, under the same circumstances. The percentage of physical abuse was 83.3 percent in those cases where perpetrators had become more dependent and 40.0 percent where their dependency status remained the same. There was a 0.0 percent rate of passive neglect in cases where perpetrators had become more dependent, compared to 49 percent when the dependency needs of perpetrators had remained stable.

Relationship dynamics between perpetrators and victims. The relationship between a perpetrator and the elderly victim was a significant factor in cases of material abuse and active neglect (Table 4.8). With regard to material abuse, the abusers were most apt to be adult children (daughters, 66.7 percent and sons, 61.5 percent) and non-relatives (80.0 percent) whereas 40.0 of the wives were involved in this type of victimization, 16.7 percent of the distant relatives and siblings, and 6.7 percent of the husbands. Eighty (80.0) percent of all wives who were perpetrators were involved in active neglect in contrast to 20.0 percent for non-relatives, 16.7 percent for distant relatives, 15.4 percent for

TABLE 4.5 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S PROBLEMS WITH INSTRUMENTAL ACTIVITIES OF DAILY LIVING - WORCESTER

Instrumental Activities	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Personal care:						
Problem	41	39.0	64.3	35.7	19.0	52.4
No problem	15	66.7	93.8	50.0	6.3	18.8
		NS	p<.05	NS	NS	p<.05
b) Meal preparation:						
Problem	43	39.5	63.6	38.6	18.2	50.0
No problem	14	64.3	100.0	40.0	6.7	20.0
		NS	p<.01	NS	NS	p<.05
c) Shopping:						
Problem	38	42.1	66.7	33.3	17.9	53.8
No problem	19	52.6	85.0	50.0	10.0	20.0
		NS	NS	NS	NS	p<.05
d) Household management:						
Problem	42	35.7	62.8	32.6	18.6	53.5
No problem	15	73.3	100.0	56.3	6.3	12.5
		p<.05	p<.01	NS	NS	p<.01

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

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TABLE 4.6 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S DEPENDENCY STATUS* - WORCESTER

Dependency Status	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Financial management:						
Independent	18	61.1	94.4	44.4	11.1	5.6
Slightly dependent	2	0.0	100.0	50.0	0.0	50.0
Very dependent	35	42.9	61.1	38.9	19.4	58.3
		NS	$p<.05$	NS	NS	$p<.01$
b) Companionship:						
Independent	12	50.0	91.7	58.3	8.3	8.3
Slightly dependent	10	50.0	90.0	50.0	0.0	40.0
Very dependent	34	41.2	61.1	27.8	22.2	52.8
		NS	$p<.05$	NS	NS	$p<.05$
c) Transportation:						
Independent	20	50.0	95.2	52.4	4.8	9.5
Slightly dependent	4	75.0	75.0	100.0	25.0	50.0
Very dependent	29	37.9	58.6	24.1	24.1	58.6
		NS	$p<.05$	$p<.01$	NS	$p<.01$
d) Daily needs:						
Independent	20	55.0	95.5	45.5	9.1	18.2
Slightly dependent	5	80.0	80.0	60.0	0.0	20.0
Very dependent	31	32.3	54.8	32.3	22.6	61.3
		NS	$p<.01$	NS	NS	$p<.01$
e) Property maintenance:						
Independent	17	52.9	84.2	47.4	15.8	15.8
Slightly dependent	9	66.7	100.0	44.4	0.0	33.3
Very dependent	27	29.6	51.9	33.3	22.2	55.6
		NS	$p<.01$	NS	NS	$p<.05$

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

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TABLE 4.7 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY PERPETRATOR'S HEALTH AND DEPENDENCY STATUS* - WORCESTER

	All Cases	Physical Abuse	Psychological Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Health Status						
A recent decline	21	52.4	78.3	17.4	8.7	34.8
No recent decline	36	41.7	69.4	52.8	19.4	47.2
		NS	NS	$p<.01$	NS	NS
b) Dependency Status						
A recent increase	6	83.3	100.0	28.6	14.3	0.0
No recent increase	50	40.0	68.6	41.2	15.7	49.0
		$p<.05$	NS	NS	NS	$p<.05$

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

sons, 11.1 percent for daughters, and 0.0 percent for husbands and siblings.

With respect to interpersonal dynamics between perpetrators and victims, Table 4.9 illustrates that, the better is the perceived relationship between the two parties, the higher are the rates of passive neglect. The percentage of passive neglect was 31.8 percent for all cases where perpetrators and victims had a "poor" relationship compared to 66.7 percent the relationship was perceived as "good" (there was only one case in which the relationship was perceived as "excellent"). Psychological abuse was more likely to occur if a perpetrator was seen as having unrealistic expectations of the elderly victim. A significantly higher percentage of this type of abuse (89.5 percent) was found when expectations were unrealistic, compared to cases in which such expectations were absent (44.4 percent).

External Stresses

The impact of recent external stresses on perpetrators imposed by their financial problems and the provocative behavior of elderly victims on acts of abuse and neglect are depicted in Table 4.10. A significantly higher rate of psychological abuse was found in cases where perpetrators had experienced recent financial problems, whereas the rate of passive neglect was significantly lower under the same circumstances. Of abusers who had experienced recent financial problems, 91.7 percent were involved in acts of psychological abuse, compared to 60.0 percent of those who had not experienced recent financial difficulties. On the other hand, the rates of passive neglect were 25 percent when perpetrators had financial problems and 54.3 percent when these problems were absent.

An increase in provocative behavior by an elderly victim was a significant factor contributing to cases of physical abuse where significantly higher rate of material abuse was found in cases where perpetrators had not become more provocative. The percentage of physical abuse was 68.2 percent when provoction was present 31.4 percent when no such behavior was evident. The rate of material abuse, on the other hand, was 18.2 percent for cases involving increased provocation and 57.4 percent for cases where an increase in this behavior was not a factor.

Social Networks and Isolation

A shared residence by perpetrators and victims was a significant factor in cases of physical abuse, whereas significantly higher rates of material abuse were found when victims lived alone, albeit with frequent social contacts (Table 4.11). Rates of active neglect were significantly higher when perpetrators and victims lived apart.

When victims and perpetrators shared the same living quarters, the percentage of physical abuse was 53.2 percent, compared to 10.0 percent when they lived apart. For cases of active neglect the rate of abuse was 10.2 percent when the two parties were in separate dwellings and 40.0 percent when they resided in the same household. Of those cases where perpetrators and victims lived together, the rate of material

TABLE 4.8 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT BY VICTIM-PERPETRATOR RELATIONSHIP - WORCESTER

Victim-Perpetrator Relationship	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
Husband	13	69.2	86.7	6.7	0.0	26.7
Wife	5	20.0	40.0	40.0	80.0	40.0
Son	13	38.5	69.2	61.5	15.4	46.2
Daughter	9	66.7	88.9	66.7	11.1	55.6
Siblings	6	33.3	83.3	16.7	0.0	66.7
Other relative	6	33.3	50.0	16.7	16.7	50.0
Non-relative	5	20	60.0	80.0	20.0	20.0
		NS	NS	$p<.01$	$p<.01$	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

TABLE 4.9 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM-PERPETRATOR DYNAMICS* - WORCESTER

Interpersonal Dynamics	All Cases	Physical Abuse	Psychological Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Quality of relationship:						
Poor	42	50.0	79.5	40.9	15.9	31.8
Good	12	41.7	66.7	33.3	16.7	66.7
Excellent	1	0.0	0.0	0.0	0.0	101.0
		NS	NS	NS	NS	$p<.05$
b) Perpetrator has unrealistic expectations of victim:						
Yes	19	55.6	89.5	31.6	10.5	42.1
No	9	44.4	44.4	22.2	22.2	55.6
		NS	$p<.05$	NS	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

TABLE 4.10 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY EXTERNAL STRESS ON PERPETRATOR - WORCESTER

External Stress	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Recent financial problems:						
Yes	23	56.5	91.7	41.7	12.5	25.0
No	34	38.2	60.0	37.1	17.1	54.3
		NS	p<.01	NS	NS	p<.05
b) Provocative behavior of victims:						
A recent increase	22	68.2	77.3	18.2	9.1	56.0
No recent increase	35	31.4	70.3	51.4	18.9	37.8
		p<.01	NS	p<.05	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

TABLE 4.11 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S SOCIAL NETWORK - NETWORK

Social Network	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Living situation:						
Lives alone	8	12.5	50.0	75.0	37.5	50.0
Lives with other	49	51.0	76.5	33.3	11.8	41.2
		$p<.05$	NS	$p<.05$	NS	NS
Victim-Perpetrator						
Live together	47	53.2	77.6	30.6	10.2	42.9
Live apart	10	10.0	50.0	80.0	40.0	40.0
		$p<.05$	NS	$p<.01$	$p<.05$	NS
b) Frequency of social contacts:						
Daily	11	36.4	81.8	72.7	27.3	36.4
Weekly	20	45.0	70.0	45.0	20.0	35.0
Monthly	11	54.5	90.9	18.2	0.0	54.5
None	10	50.0	60.0	20.0	10.0	50.0
		NS	NS	$p<.05$	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

abuse was 30.6 percent, compared to 80.0 percent when they lived apart. Victims of material abuse, however, were not isolated socially. Of all victims with social contacts with people (other than professionals or perpetrators), on a daily basis, 72.2 percent were involved in material abuse in contrast to a rate of 20.0 percent for those victims who are socially isolated and 18.2 percent when social contacts were infrequent, i.e., once a month.

The status of the social network of perpetrators was a factor in abuse/neglect cases (Table 4.12). The rate of physical abuse was 80.0 percent in cases where perpetrators did not have family members available for support, compared to 40.6 percent when support was available. When perpetrators were very isolated, with no available emergency contact, The percentage of passive neglect was significantly higher (100.0 percent) than in cases where this contact was available (45.7 percent). The percentage of material abuse was 45.8 percent in cases where the support system had remained stable and 10.0 percent when a recent loss in supports had been suffered.

B. Discussion

In analyzing the Worcester data some general statements can be made about each type of abuse and neglect, particularly with respect to the contribution of factors under investigation. The few cases of active neglect (i.e., nine), however, do not allow any causal postulates to be suggested.

Passive neglect seems very clearly related to the dependency needs of elderly victims, as an outcome of their impairments. Elderly victims in these situations have failing mental health, impaired cognitive functioning and decreased ability to perform fundamental activities of daily living. They have on-going or intermittent problems with orientation and memory and significant problems with personal care, meal preparation, shopping and household management. Because a significant percentage of victims of passive neglect are likely to decline in their mental health, they find themselves dependent with respect to their financial management, companionship, transportation, property maintenance and daily needs.

Perpetrators of passive neglect appear to be in sound mental health. Higher rates of passive neglect are, in fact, found in cases where the perpetrators have no recent decline in mental health nor increases in provocative behavior and dependency needs. In a significant percentage of cases, the relationship between the victim and perpetrator is considered "good." Perpetrators are somewhat isolated, a significant number being without emergency contacts. In summary, then, it appears that passive neglect is largely associated with the dependency needs of the elderly.

Victims of psychological abuse are relatively unimpaired with respect to their cognitive ability and functional status. Significantly higher percentages of psychological abuse are found in cases where victims do not have problems with orientation, memory and their ability to give consent, or with personal care, meal preparation and household

TABLE 4.12 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY PERPETRATOR'S SOCIAL NETWORK* - WORCESTER

Social Network	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Support system dynamics:						
A recent loss of supports	10	70.0	70.0	10.0	0.0	60.6
No recent loss of supports	46	39.1	72.9	45.8	18.8	39.6
		NS	NS	$p<.05$	NS	NS
b) Familial supports:						
Family members available for support	32	40.6	67.6	29.4	20.6	47.1
No family members available for support	10	80.0	90.0	50.0	0.0	40.0
		$p<.05$	NS	NS	NS	NS
c) Emergency contact:						
Yes	33	48.5	71.4	34.3	17.1	45.7
No	4	50.0	50.0	25.0	0.0	100.0
		NS	NS	NS	NS	$p<.05$

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

management. The lowest rates of this type of abuse are found in cases where victims are very dependent with respect to financial management. A significantly higher percentage of psychological abuse is found, however, in cases where the emotional status of victims is considered "poor." This finding, in conjunction with the significant relationship between a perpetrator's unrealistic expectations of victims and cases of psychological abuse, indicates that interpersonal psychological dynamics may play an important role. Perpetrators in these cases are financially dependent on victims in significantly high proportions.

The relatively small number of material abuse cases (i.e., 23) makes the determination of significant relationships hard to achieve. A significantly high percentage of perpetrators of material abuse are adult children under 50 years of age and in good physical health. Victims, who tend to live apart from their perpetrators, are not provocative, and have a relatively large intact social network. Insufficient cases do not permit significance to be determined in the relationship between the financial status of victims and cases of material abuse. In the 23 cases of material abuse, however, two perpetrators were reported to be independent with respect to finances, 5 were slightly dependent and 9 were very dependent on the victim for financial needs; and no data was available in 7 cases.

The mental health status of perpetrators is an important factor in cases of physical abuse with a significant percentage of cases involving perpetrators who have suffered a recent decline in mental health. As a possible outcome of their mental health status, perpetrators of physical abuse have a significant increase in recent dependency needs. At the same time, perpetrators of physical abuse find themselves faced with increasingly provocative behavior by elderly victims. From the data, it appears that problems in the relationship between the perpetrator and victim involving dependency dynamics play an important role in these cases. The increasingly dependent perpetrator, in declining mental health, finds himself or herself baited by the elderly victim. Under these circumstances, the burden of caretaking is probably too great for the perpetrator. The pathology of the relationship is probably compounded by a common residence and the absence of familial supports for the perpetrator.

II. Syracuse

A. Results

Characteristics of the Victims

None of the sociodemographic variables for the victim in the analysis (age, sex or marital status) was significantly related to forms of abuse or neglect except income level with regard to active neglect ($p < .05$). The highest rate of this form of victimization (37.5 percent) occurred in those victims with the lowest income (less than $5,000). Of all victims earning between $5,000-$10,000, the percentage of passive neglect was 10 percent and for those with incomes between $10,000-$15,000, the percentage was 12.5 percent.

Characteristics of the Perpetrators

The age of the perpetrator was a significant factor in cases of physical and material abuse, but unrelated to other types of abuse and neglect (Table 4.13). The percentage of physical abuse was highest (66.7 percent) for those perpetrators who were over 80 years of age, and next highest (61.5 percent) for those between 70-79 years while the lowest rates of physical abuse were found for perpetrators between the ages of 50-59 years (18.2 percent) and 30-49 (20.6 percent). The highest rates of material abuse occurred if perpetrators were less than 30 years (72.7 percent) or between 30-49 years (67.6 percent) and the lowest rates were found if abusers were over 80 years (6.7 percent) or between 60-69 years (12.1 percent).

As Table 4.14 indicates the recent deterioration of the mental health of the perpetrator is a significant factor in cases of physical abuse. Forty-six percent (46.4 percent) of all perpetrators who experienced a decline in mental functioning were involved in acts of physical abuse in contrast to 27.4 percent of physical abuse for perpetrators whose mental health was judged to be stable. A change in the perpetrator's psychological status was not related to the other types of abuse/neglect, nor was the presence or absence of a history of mental or emotional problems in the perpetrator related to any type of abuse/neglect. A specific indicator of the perpetrator's mental health, alcohol abuse, was found to be related significantly to cases of material abuse only. Fifty-three (53.1) percent of all perpetrators suffering from alcohol abuse committed acts of material abuse compared to 28.4 percent of all perpetrators who were judged not to have problems with alcohol.

Dependency Status of the Victim

Mental status. Elderly clients who had suffered a decline in their mental health status prior to their being abused or neglected were victims of passive neglect at a significantly higher rate (66.2 percent) than those whose mental status had remained stable (41.3 percent) (Table 4.15). A recent change in a client's mental health was not significantly related to other forms of abuse or neglect. Neither the emotional state nor self-esteem of elderly victims, as assessed by caseworkers, was significantly related to any type of abuse or neglect. The relationship between the elder victim's emotional state and the occurrence of physical abuse was interesting and approached significance ($p = .06$), however. The rate of physical abuse in victims whose emotional state was perceived as "good" was 22 percent. This rate jumped to 43 percent in those victims whose emotional state was perceived as "poor."

Cognitive functioning. According to Table 4.15, the level of cognitive functioning of elder victims, as evidenced by their degree of orientation and ability to give consent, is related to the occurrence of psychological abuse and neglect but unrelated to cases of physical and material abuse. With respect to psychological abuse it can be seen that occurrence of psychological abuse is significantly highest for those with the best cognitive functioning. Of all the victims who are oriented to person, place and time, over 90 percent are psychologically abused. The percentage of such cases among those with some degree of

TABLE 4.13 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY PERPETRATOR'S AGE* - SYRACUSE

Perpetrator's Age	All Cases	Physical Abuse	Psychological Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
< 30	11	36.4	81.8	72.7	0.0	36.4
30 - 49	34	20.6	70.6	67.6	29.4	52.9
50 - 59	22	18.2	63.6	50.0	27.3	52.9
60 - 69	33	45.5	75.8	12.1	27.3	63.6
70 - 79	13	61.5	76.9	23.1	38.5	61.5
> 80	15	66.7	73.3	6.7	20.0	40.0
		p<.01	NS	p<.001	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

TABLE 4.14 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY PERPETRATOR'S PSYCHOLOGICAL STATUS - SYRACUSE

Psychological Status	All Cases	Physical Abuse	Psychological Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Mental health changes						
A recent decline	69	46.4	76.8	33.3	26.1	56.5
No recent decline	62	27.4	64.5	45.2	27.4	53.2
		$p<.05$	NS	NS	NS	NS
b) Problem with alcohol abuse						
No	74	37.8	79.7	28.4	23.0	48.6
Yes	49	40.8	65.3	53.1	28.6	65.3
		NS	NS	$p<.01$	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

TABLE 4.15 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S MENTAL HEALTH AND COGNITIVE STATUS* - SYRACUSE

	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
Mental health status						
recent decline	71	35.2	66.2	33.8	29.6	66.2
no recent decline	63	39.7	77.8	44.4	23.8	41.3
		NS	NS	NS	NS	p<.01
a) Orientation to person						
On-going problem	17	41.2	64.7	23.5	23.5	47.1
Intermittent problem	59	33.9	61.0	33.9	27.1	69.5
No problem	51	37.3	90.2	51.0	23.5	41.2
		NS	p<.01	NS	NS	p<.01
b) Orientation to place						
On-going problem	20	35.0	45.0	20.0	30.0	55.0
Intermittent problem	47	29.8	61.7	38.3	27.7	72.3
No problem	61	41.0	90.2	45.9	23.0	42.6
		NS	p<.01	NS	NS	p<.01
c) Orientation to time						
On-going problem	21	28.6	38.1	19.0	47.6	66.7
Intermittent problem	60	40.0	70.0	40.0	21.7	65.0
No problem	47	36.2	91.5	46.8	19.1	38.3
		NS	p<.001	NS	p<.05	p<.05
d) Immediate memory						
On-going problem	28	35.7	46.4	28.6	35.7	60.7
Intermittent problem	51	35.3	70.6	43.1	21.6	62.7
No problem	47	38.3	89.4	42.6	21.3	44.7
		NS	p<.001	NS	NS	NS
e) Recent memory						
On-going problem	27	33.3	40.7	29.6	33.3	63.0
Intermittent problem	55	40.0	74.5	36.4	18.2	61.8
No problem	45	35.6	88.9	51.1	26.7	42.2
		NS	p<.001	NS	NS	NS
f) Remote memory						
On-going problem	23	34.8	39.1	30.4	21.7	65.2
Intermittent problem	48	35.4	70.8	33.3	27.1	62.5
No problem	54	37.0	87.0	48.1	22.2	46.3
		NS	p<.001	NS	NS	NS
g) Ability to consent						
Can give consent	106	37.7	77.4	41.5	25.5	50.9
Cannot give consent	19	42.1	36.8	26.3	36.8	73.7
		NS	p<.001	NS	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

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orientation impairment ranges from 38.5 percent for those with an on-going problem with orientation to time, to 70 percent for those with an intermittent problem. Just under 90 percent of all victims who have an absence of memory problems are psychologically abused while the percentage of such cases in victims with some degree of memory impairment ranges from 39.1 percent for those with an on-going problem with remote memory to 74.5 percent for those with an intermittent problem with recent memory. In a further test of cognitive ability, a victim's ability to give consent was also found to be related to cases of psychological abuse. Again, victims with a higher cognitive functioning had a higher occurrence of psychological abuse. Seventy-seven (77.4) percent of all elder clients who could give consent were victims of this type of abuse, compared to 36.8 percent of all victims who could not give consent.

On the other hand, the occurrence of active and passive neglect is higher for those victims who have some degree of impairment with respect to orientation. Forty-eight (47.6) percent of all victims with this impairment were victims of willful negligence in contrast to to 19.1 percent of all victims with no such problem. Elder victims' orientation status with respect to person, place and time were all related to the frequency of passive neglect cases. Whereas the latter type of abuse/neglect occurred in approximately two-fifths of all cases in which each type of orientation impairment existed, the comparable proportion when some degree and type of impairment was found ranged from almost one-half to three-quarters of the cases.

Instrumental activities of daily living. Table 4.16 depicts the relationship between victims' status with respect to their ability to perform instrumental activities of daily living and the occurrence of abuse/neglect. In general, the ability to perform selected instrumental activities is related, in different degrees, to psychological abuse and both types of neglect, but unrelated to physical and material abuse. Several variables measuring this dimension, i.e., personal care, security of property, management of personal affairs and household management are related significantly to the occurrence of psychological abuse. For all significant variables, the percentage of psychological abuse was approximately (90 percent) in cases where there was an absence of a problem performing the specific activity compared to an occurrence of between 64 percent and 69 percent in cases where such problems existed. Personal care, security of property, management of personal affairs and household management are factors which impact significantly on the occurrence of active neglect as well as psychological abuse. In cases of active neglect, however, the rates of perpetration are higher for victims with a lower level of functioning. For all significant variables, the percentage of active neglect was approximately 30 percent in cases where there was a problem performing the specific instrumental activity while in cases where problems were absent, it occurred between 0 and 13 percent. An ability to perform activities related to personal care, mobility, management of personal affairs and household, and transporation is associated with the prevalence of passive neglect. The rates of this form of victimization are higher for elders with a lower level of functioning. For all significant variables, the percentage of

TABLE 4.16 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S PROBLEMS WITH INSTRUMENTAL ACTIVITIES OF DAILY LIVING* - SYRACUSE

Instrumental Activity of Daily Living Status	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Personal care						
Problem	107	33.6	66.4	42.1	30.8	61.7
No problem	26	53.8	92.3	26.9	7.7	23.1
		NS	$p<.01$	NS	$p<.05$	$p<.001$
b) Mobility						
Problem	111	35.1	68.5	37.8	27.9	64.0
No problem	22	50.0	86.4	45.5	18.2	4.3
		NS	NS	NS	NS	$p<.001$
c) Safety/security of property						
Problem	94	33.0	63.8	40.4	30.9	59.6
No problem	38	47.4	89.5	34.2	13.2	42.1
		NS	$p<.01$	NS	$p<.05$	NS
d) Managing personal affairs						
Problem	118	37.3	68.6	37.3	29.7	58.5
No problem	15	40.0	93.3	53.3	0.0	20.0
		NS	$p<.05$	NS	$p<.05$	$p<.01$
e) Transporation						
Problem	120	35.0	70.0	39.2	28.3	57.5
No problem	13	61.5	84.6	38.5	7.7	23.1
		NS	NS	NS	NS	$p<.05$
f) Household management						
Problem	112	36.6	67.9	39.3	29.5	60.7
No problem	20	45.0	90.0	40.0	5.0	20.0
		NS	$p<.05$	NS	$p<.05$	$p<.001$

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

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passive neglect was approximately 60 percent in cases where there was a problem performing the specific instrumental activity but only between 4 and 23 percent in cases where problems were absent.

An additional item not included in Table 4.16, an elder victim's need for a supportive device for movement, was found to be significantly related only to cases of passive neglect ($p < .01$). Of 64 victims requiring a supportive device, 65.6 percent were cases of this type of abuse/neglect whereas of 53 elder clients who did not require such a device, 41.5 percent were cases of passive neglect.

Specific dependencies. In Table 4.17 the relationships between various elder client dependencies and the occurrence of abuse/ neglect are outlined. As a group, elderly victims are very dependent on their caretakers for management of finances, companionship, activities of daily living, property maintenance and transportation in 68 percent or more cases, but they are relatively independent with respect to financial resources (62 percent of cases). Dependency needs of elderly clients are significantly related to all types of abuse/neglect. The rates of physical abuse are highest for clients who are most dependent with respect to financial resources and companionship. Sixty-one (60.9) percent of all clients who are very dependent on caretakers for financial resources are physically abused compared to 27.0 percent of clients who are economically independent. Similarly, forty-three (42.9) percent of victims who are very dependent on caretakers for companionship needs are physically abused compared to 11.1 percent who are slightly dependent and 33.3 percent who are independent.

The dependency status of elder clients regarding financial management, transportation and activities of daily living is significantly related to the occurrence of psychological abuse. In cases where elder clients are independent in terms of their needs in these areas, the percentage of psychological abuse is 95 percent or more but those who are very dependent, the comparable percentage is between 67 and 69 percent. An elder client's dependency status with respect to companionship is related to the occurrence of material abuse although the rates of this type of abuse are identical for those who are independent and very dependent (33.3 percent). Sixty-seven (66.7 percent) of elder clients who are slightly dependent on caretakers for companionship needs are victims of material abuse.

The dependency needs of elderly victims in terms of financial resources, financial management, transportation and activities of daily living are significantly related to cases of active neglect. The rates of this type of neglect are highest for clients who are very dependent for these needs. Of all elderly victims who are very dependent for their financial needs 52.2 percent are neglected willfully compared to 14.9 percent of those who are independent on this item. Where there is an absence of active neglect for elderly clients who are independent in their financial management needs, 38.6 percent are victims of this form of victimization if they are very dependent. Active neglect occurs in about one-third of elderly victims who are very dependent for their transporation needs (34.9 percent) and activities of

TABLE 4.17 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S DEPENDENCY STATUS - SYRACUSE

Dependency Status	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Financial resources						
Independent	74	27.0	73.0	43.2	14.9	64.9
Slightly dependent	22	54.5	68.2	31.8	27.3	40.9
Very dependent	23	60.9	69.6	17.4	52.2	52.2
		p<.01	NS	NS	p<.01	NS
b) Financial management						
Independent	19	31.6	94.7	42.1	0.0	42.1
Slightly dependent	22	45.5	77.3	45.5	4.5	54.5
Very dependent	88	38.6	67.0	34.1	38.6	59.1
		NS	p<.05	NS	p<.001	NS
c) Companionship						
Independent	6	33.3	83.3	33.3	16.7	16.7
Slightly dependent	18	11.1	77.8	66.7	16.7	55.6
Very dependent	105	42.9	72.4	33.3	29.5	58.1
		p<.05	NS	p<.05	NS	NS
d) Transportation						
Independent	25	44.0	96.0	36.0	8.0	32.0
Slightly dependent	13	23.1	61.5	53.8	23.1	69.2
Very dependent	83	41.0	68.7	34.9	34.9	63.9
		NS	p<.05	NS	p<.05	p<.05
e) Activities of daily living						
Independent	16	31.3	100.0	43.8	0.0	25.0
Slightly dependent	17	41.2	70.6	52.9	23.5	52.9
Very dependent	95	40.0	68.4	33.7	33.7	61.1
		NS	p<.05	NS	p<.05	p<.05
f) Property maintenance						
Independent	12	25.0	100.0	50.0	8.3	25.0
Slightly dependent	19	47.4	78.9	47.4	10.5	47.4
Very dependent	84	36.9	69.0	35.7	32.1	65.5
		NS	NS	NS	NS	p<.05

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

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daily living (33.7 percent) but on less than one-tenth (8 percent) of those who are independent in transportation and absent (0.0 percent) with respect to activities of daily living. The needs of the elderly for transportation, activities of daily living and property maintenance are all related to the occurrence of passive neglect. The percentage of passive neglect is over 60 percent for elderly clients who are very dependent for the above needs, and between 25 and 32 percent for those who are independent.

Dependency Status of the Perpetrator

As indicated in Table 4.18 the health status of perpetrators impacts on physical, psychological and material abuse but not active or passive neglect. Caretakers who have short and long-term health problems are more likely to perpetrate psychological abuse than those without such problems. The percentage of psychological abuse among perpetrators who have long-term medical problems was 84.8 percent compared to 67.5 percent for those without such problems. Also, eighty-seven (87) percent of perpetrators with short-term health problems inflict psychological abuse on their elderly victims compared to 63.8 percent for those without physical problems. Caretakers who have experienced recent health problems perpetrate physical abuse at a significantly higher rate (51.9 percent) than those without such problems (29.0 percent). As a corollary to this, 60.8 percent of the perpetrators had experienced a recent decline in health compared to 22.5 percent for those whose health had remained stable. Higher rates of material abuse (47.5 percent) were found in those perpetrators whose health had remained stable compared to 25.5 percent for those whose health had declined.

A change in the dependency status of perpetrators was not a significant factor contributing to any type of abuse (Table 4.18). That is to say perpetrators were not seen as having become more dependent personalities immediately prior to initiating acts of abuse or neglect. However, the dependency status of perpetrators was significantly related to acts of passive neglect. The percentage of passive neglect by perpetrators was higher (31.6 percent) for those who had not experienced an increase in dependency needs whereas only 9.4 percent of those who experienced an increase in dependency had been identified as perpetrators of passive neglect. In terms of specific dependency needs, the rate of material abuse was significantly highest (64.4 percent) for those perpetrators who were perceived as very dependent on the abuse/neglect elder for finances, and least (19.6 percent) for those who were seen as independent.

Relationship dynamics between perpetrators and victims. The existence of unrealistic expectations of a perpetrator on an elder victim was a significant factor only in cases of psychological abuse (Table 4.19). Eighty-one (81) percent of perpetrators who had such unrealistic expectations committed acts of psychological abuse; when unrealistic expectations were absent, psychological abuse was found in 64.3 percent of cases. The quality of the relationship between perpetrators and victims, as perceived by the caseworkers was related significantly only to cases of psychological abuse. For cases where the relationship was

TABLE 4.18 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY PERPETRATOR'S HEALTH AND DEPENDENCY STATUS

	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
Health Status	#	%	%	%	%	%
a) Long-term health problem						
No	77	35.1	67.5	41.6	24.7	54.5
Yes	46	45.7	84.8	32.6	26.1	56.5
		NS	p<.05	NS	NS	NS
b) Short-term health problem						
No	69	29.0	63.8	44.9	21.7	53.6
Yes	54	51.9	87.0	29.6	29.6	57.4
		p<.01	p<.01	NS	NS	NS
c) Recent decline in health						
No	80	22.5	65.0	47.5	27.5	58.8
Yes	51	60.8	80.4	25.5	25.5	49.0
		p<.001	NS	p<.05	NS	NS
Dependency Status						
a) General increase in dependency needs						
Yes	32	46.9	81.3	40.6	40.6	9.4
No	98	34.7	67.3	37.8	37.8	31.6
		NS	NS	NS	NS	p<.05
b) Financial needs						
Independent	51	39.2	66.7	19.6	29.4	62.7
Slightly dependent	28	46.4	64.3	39.3	28.6	50.0
Very dependent	45	33.3	82.2	64.4	17.8	46.7
		NS	NS	p<.001	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

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TABLE 4.19 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM-PERPETRATOR DYNAMICS* - SYRACUSE

Interpersonal Dynamics	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Perpetrator has unrealistic expectations of victim						
Yes	58	44.8	81.0	32.8	25.9	48.3
No	56	33.9	64.3	42.9	19.6	66.1
		NS	p<.05	NS	NS	NS
b) Quality of relationship						
Poor	93	41.9	79.6	35.5	28.0	49.5
Good	36	27.8	52.8	47.2	16.7	66.7
Excellent	1	0.0	0.0	0.0	100.0	100.0
		NS	p<.01	NS	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

judged as "poor" the percentage of psychological abuse was 79.6 percent compared to 52.8 percent for cases where it was seen as "good."

According to Table 4.20, the relationship of the perpetrator to an elder client was a significant factor in cases of physical abuse and material abuse but unrelated to the other types of abuse/ neglect. The percentage of physical abuse cases was highest between spouses. Seventy (70.4) percent of all maltreatment by husbands involved physical abuse; the comparable figure for wives was 60 percent. The lowest occurrence of physical abuse was found in perpetrators unrelated to elder clients (18.3 percent) or distant ("other") relatives (18.2 percent). The situation was reversed in cases of material abuse with the highest occurrence of the latter type of abuse perpetrated by non-relatives (66.7 percent) and distant ("other") relatives (59.1 percent). The lowest rates were found in wives (10 percent) and husbands (11.1 percent).

External Stresses

Recent stresses exerted externally on both victims and perpetrators, which were seen by caseworkers to be possible precipitants of abuse or neglect, were significant factors in cases of physical and material abuse and passive neglect. A change in the living situation of elderly clients was seen as a significant precipitant of cases of physical and material abuse and passive neglect (Table 4.21). The rate of physical abuse was higher (47.5 percent) for elderly victims who had not experienced a recent change in their living situation, compared to those who had experienced a change (28.8 percent). On the other hand, material abuse and passive neglect occurred more frequently if elderly clients had altered their living situation. The rate of material abuse was 54.8 percent where a change had occurred, compared to 19.7 percent where the living situation had remained the same. Sixty-three (63) percent of all elderly clients who had changed their living situations were victims of passive neglect, compared to 44.3 percent for those whose status remained the same.

The perception, by caseworkers, of the elderly victim as a source of stress because of their impairments and dependencies to the caretakers was significantly related to the occurrence of physical and material abuse only (Table 4.22). Elderly clients who were perceived as being the greatest source of stress to caretakers had the highest rates of physical abuse (50.7 percent) in comparison with 13.3 percent of elders who were not seen as stressors to caretakers. In the case of material abuse its highest occurrence was present (60.0 percent) when elderly clients were seen as least stress inducing.

External stresses on perpetrators, related to job status, finances and loss of spouse, were significant factors in cases of material abuse and passive neglect (Table 4.23). Financial burdens and a recent divorce or separation contributed to cases of material abuse. Fifty-seven (57.4) percent of all perpetrators who had a recent change in their financial or job status, committed acts of material abuse, for those perpetrators without such a change, the rate was 22.9 percent. Material abuse occurred in three out of five abusers who were experienc-

TABLE 4.20 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM-PERPETRATOR RELATION-SHIP* - SYRACUSE

Perpetrator-Victim Relationship	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
Husband	27	70.4	81.5	11.1	37.0	44.4
Wife	10	60.0	90.0	10.0	0.0	40.0
Son	32	31.3	62.5	50.0	21.9	56.3
Daughter	23	34.8	82.6	34.8	30.4	69.6
Sibling	5	20.0	60.0	20.0	40.0	80.0
Other relative	22	18.2	68.2	59.1	31.8	40.9
Non-relative	15	18.3	53.3	66.7	20.0	66.7
		p<.001	NS	p<.001	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

TABLE 4.21 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY EXTERNAL STRESSES ON ELDERLY VICTIMS* - SYRACUSE

External Stresses	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
Living situation	#	%	%	%	%	%
A recent change	73	28.8	65.8	54.8	30.1	63.0
No recent change	61	47.5	78.7	19.7	23.0	44.3
		$p<.05$	NS	$p<.001$	NS	$p<.05$

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

TABLE 4.22 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM AS A SOURCE OF STRESS - SYRACUSE

Source of Stress	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
A lot	73	50.7	78.1	28.8	28.8	50.7
A little	42	21.4	64.3	52.4	28.6	69.0
Not at all	15	13.3	60.0	60.0	13.3	40.0
		p<.001	NS	p<.05	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

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TABLE 4.23 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY EXTERNAL STRESSES ON PERPETRATORS* - SYRACUSE

External Stress	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Recent change in financial or job status						
No	70	41.4	64.3	22.9	31.4	60.0
Yes	61	32.8	78.7	57.4	21.3	49.2
		NS	NS	p<.001	NS	NS
b) Short-term financial problems						
No	70	48.6	80.0	21.4	27.1	55.7
Yes	54	25.9	66.7	61.1	22.2	53.7
		p<.05	NS	p<.001	NS	NS
c) Long-term financial problems						
No	78	41.0	76.9	24.4	28.2	51.3
Yes	45	35.6	68.9	62.2	20.0	62.2
		NS	NS	p<.001	NS	NS
d) Recent death of spouse						
No	110	39.1	72.7	36.4	25.5	51.8
Yes	13	38.5	84.8	53.8	23.1	84.6
		NS	NS	NS	NS	p<.05
e) Recent divorce or separation						
No	101	41.6	74.3	32.7	25.7	52.5
Yes	22	27.3	72.7	63.6	22.7	68.2
		NS	NS	p<.01	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

ing either short (61.1 percent) or long (62.2 percent) term financial problems and in a little more than one out of five for those without such problems (21.4 and 24.4 percent, respectively). Perpetrators of material abuse were also more likely to have experienced a recent divorce or separation, as evidenced by the fact that the percentage of material abuse was 63.6 percent for those who had experienced such a loss, compared to 32.7 percent for those who had not been divorced or separated. The rate of physical abuse was significantly higher (48.6 percent) for those perpetrators without short-term financial problems in contrast to those with such problems (25.9 percent). The recent death of a spouse was a contributing factor to cases of passive neglect. Eighty-five (84.6) percent of all perpetrators who had lost a spouse were involved in passive neglect, compared to 51.8 percent of those who had not suffered such a loss.

Social Networks and Isolation

The status of the social network of elderly victims was a factor in all cases of abuse/neglect (Table 4.23). Elderly victims who lived with others, specifically a perpetrator, and had their support system intact, were more likely to be physically abused than victims with these factors absent. About one-half of those living with others (46.9 percent) and those living with a perpetrator (48.9 percent) were physically abused, whereas about one eighth of victims living alone (13.5 percent) living apart from their perpetrators (11.6 percent) were subject to such abuse. The percentage of those physically abused who had suffered a loss of social supports was 29.5 percent compared to 48.2 percent for victims whose social supports remained stable. The rate of psychological abuse was highest for those victims who had three or more social contacts outside the perpetrator. Between 56 percent and 59 percent of victims with one or two social contacts were psychologically abused, while the rate was between 70 percent and 89 percent for those with three or more contacts. The rate of psychological abuse was 84.1 percent for those victims with an emergency contact and 44.7 percent for those without. Victims of abuse/neglect were more subject to a higher rate of material abuse (47.4 percent), if they had recently experienced a loss in their support network, than those without such a loss (26.8 percent). For elderly victims without an emergency contact person, the rate of active neglect was higher (42.1 percent), compared to 20.5 percent for those with such a contact. Passive neglect also, occurred more frequently among victims who were losing their support system and who lacked a primary contact. The rate of passive neglect was 64.1 percent for those victims who had recently lost some members of their support network and 68.4 percent where an emergency contact was absent. This compares to a rate of 41.1 percent in stable support systems and 47.7 percent for victims with an emergency contact. In regards to the support system of perpetrators, the presence or absence of supportive family members was significantly related, only to material abuse ($p<.05$). The rate of material abuse was higher (54.3 percent) for victims without family support, than for those with such support (27.8 percent).

TABLE 4.24 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S SOCIAL NETWORK* - SYRACUSE

Social Network	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Living situation						
Lives alone	37	13.5	62.2	37.8	18.9	62.2
Lives with others	96	46.9	75.0	38.5	29.2	52.1
		p<.001	NS	NS	NS	NS
b) Victim-perpetrator						
Live together	90	48.9	74.4	34.4	31.1	52.2
Live apart	43	11.6	65.1	46.5	18.6	58.1
		p<.001	NS	NS	NS	NS
c) Number of social contacts						
One	25	40.0	56.0	32.0	32.0	48.0
Two	27	22.2	59.3	37.0	25.9	70.4
Three	25	48.0	88.0	44.0	24.0	48.0
Four	10	50.0	70.0	60.0	10.0	50.0
Five +	18	27.8	88.9	38.9	11.1	44.4
		NS	p<.05	NS	NS	NS
d) Support system dynamics						
A recent loss of supports	78	29.5	70.5	47.4	24.4	64.1
No recent loss of supports	56	48.2	73.2	26.8	30.4	41.1
		p<.05	NS	p<.05	NS	p<.01
e) Emergency contact						
Yes	88	42.0	84.1	35.2	20.5	47.7
No	38	28.9	44.7	39.5	42.1	68.4
		NS	p<.001	NS	p<.05	p<.05

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

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B. Discussion

A close examination of the Syracuse data permits some general statements to be made about each type of abuse and neglect, particularly with respect to the contribution of the factors under investigation, i.e., the psychological status the perpetrator, external stresses, social isolation, dependency and exchange relationships. Passive and active neglect seem very clearly related to the dependency needs of elderly victims, as an outcome of their impairments and increased social isolation. Elderly victims in neglect situations tend to have impaired cognitive and functional impairments. They are disoriented towards people and places intermittently. Both groups are functionally impaired with respect to their needs for personal care, management of personal affairs and household management. In addition, passive neglect is related to the elder's transportation and mobility requirements, whereas the need of the elder to protect his/her property, contributes to active neglect. Victims of passive neglect were seen also as suffering from a decline in their mental health. The impairments of victims of active and passive neglect made them dependent on their caretakers for significant needs. Elders who are actively neglected, are dependent for financial resources and management, while victims of passive neglect are dependent for property maintenance. Both groups are dependent for many activities of daily living and transportation needs. With respect to passive neglect, perpetrators are suffering from externally imposed stress and accompanying social isolation due in large part to recent divorce or separation. It may well be that the major differences between active and passive neglect are attributable to the increased burdens imposed by the mental impairment of elderly clients and the trauma associated with loss, in the cases of passive neglect. In summary then, it appears that neglect is, in large part associated with the dependency needs of elderly victims. The more benign quality found in cases of passive neglect is perhaps best understood by the increased burdens imposed on caretakers by the mental status of the elder client and the externally imposed stress caused by a recent divorce or separation.

Elderly victims of psychological abuse are the least impaired, the least dependent and the least socially isolated, compared to other types of elderly abuse/neglect. Victims of this type of abuse did not suffer from any significant mental or emotional disabilities. Significantly higher rates were found in cases where elderly victims had an absence of problems with cognitive functioning and performance of instrumental activities of daily living related to personal care, safety of property, and management of household and personal affairs. Higher rates of psychological abuse were found also; the more independent were victims with respect to financial management, transportation and activities of daily living.

With respect to the perpetrators of psychological abuse, they do not appear to have psychological impairments nor are they impacted by external stresses related say, to financial problems or marital problems. Their long-term health problems were, however, a significant factor in these cases. This latter finding, in conjunction with the significance of perpetrators' unrealistic expectations of victimized elders, suggests that issues related to the physical and psychological status of the perpetrator are central to understanding psychological abuse. However, the significantly higher rate of psychological abuse in cases where the relationship between perpetrator and victim is characterized as poor, may indicate the need for a word of caution before the onus of responsibility for psychological abuse is placed on the problems of the perpetrator. This latter finding may indicate that a transactional perspective, based on the interpersonal history and dynamics of the victim and the perpetrator, be best applied to understand cases of psychological abuse.

The chaotic life of the perpetrator is the key to understanding cases of material abuse. A characterization of this chaotic life, reveals a relatively young perpetrator, either a distant relative or unrelated to the victim, with alcohol problems, who is besieged by external stressors related to financial problems and a recent divorce or separation. Because of the financial problems, perpetrators of material abuse tend to be dependent on their victims for financial needs. In general, characteristics of elderly victims are not related to cases of material abuse. In fact the highest rates of material abuse are found in cases where victims are considered the least source of stress to the perpetrator. The only dependency they have on the perpetrator relates to companionship because of their own loss of social supports.

The psychological and physical impairment of the perpetrator and the victim as a source of stress because of financial and companionship needs are significant factors in cases of physical abuse. Perpetrators tend to be elders themselves and in declining mental and physical health. Although the mental, cognitive and functional ability of elderly victims are not factors in physical abuse, their dependency needs to contribute to their being perceived by caseworkers as a source of stress to their perpetrators. The highest rates of physical abuse are found when perpetrators who are a spouse or adult child are involved. Physical abuse, then, involves family members who are the most intimately related and emotionally connected. It is likely, therefore, that physical abuse has its underpinnings in long standing, pathological family dynamics and interpersonal processes which react as a flashpoint as the elder becomes an increasing source of stress, because of his/her dependency, to a perpetrator in physical and mental decline. The significance of a common residence would indicate that there is a container effect occurring which does not permit any diffusion of pathological energy. Thus in sum, physical and mental health of the perpetrator, the dependencies of elderly victims, and the nature of the exchange relationship between the two are likely to be the major factors involved in physical abuse. Factors related to external stressors and social isolation were not found to be significant in these cases.

III. Rhode Island

A. Results

Characteristics of the Victims

The elder victim's age was a significant factor in cases of physical abuse, psychological abuse and passive neglect (Table 4.25). Whereas the highest rates of physical and psychological abuse occurred in the most youthful elderly group (< 65 years), the occurrence of passive neglect was highest in the over 85 years group. The rate of physical abuse of clients between 60-65 years was 70.4 percent compared to 30 percent for those over 85 years. The rate of psychological abuse was 88.5 percent for victims 60-65 years and 50 percent for those over 85 years. The highest rate of passive neglect (35 percent) was found in the latter age group and compares to 11.5 percent for victims less than 65 years.

Only in cases of material abuse was the marital status of victims a factor (Table 4.25). In general terms, marriage seemed to inhibit this type of abuse, whereas the highest rates were found in those elders who had remained single. Sixty (60) percent of all single elders were victims of material abuse, compared to 15.8 percent of those who were still married. Approximately one out of three widowed or divorced/separated elders were victims of material abuse. The income level of elderly victims was not a significant factor in any type of abuse or neglect.

Characteristics of the Perpetrators

The sex of the perpetrator was a significant factor in cases of material abuse and passive neglect ($p < .01$), but unrelated to other types of abuse and neglect. The higher rates of material abuse were inflicted by men, whereas the higher rates of passive neglect occurred when the perpetrators were women. Eighty-four (84) percent of the total of eighty-three male perpetrators were involved in cases of material abuse. Of all male perpetrators 43.9 percent committed acts of passive neglect. The rate for women was 69.2 percent. (Table 4.25)

According to Table 4.26, psychological problems of perpetrators, as evidenced by the presence of one or more indicators of a mental or emotional disturbance, are significantly related to cases of physical and psychological abuse. Such problems seem to be particularly important in cases of physical abuse. Significantly higher rates of physical abuse were found in cases where perpetrators had a history of mental illness, a recent decline in their mental health and an increase in behavior provocative to the victim, compared to cases where these traits were absent. Of all perpetrators with a history of mental illness, 74.4 percent committed acts of physical abuse in contrast to 44 percent for perpetrators with no evidence of a history of mental illness. Seventy-five (75) percent of all perpetrators who had experienced a decline in mental health committed acts of physical abuse compared to 44.2 percent of those whose mental health had remained stable. Sixty-five (65) percent

TABLE 4.25 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S SOCIODEMOGRAPHIC CHARACTERISTICS* AND HEALTH STATUS - RHODE ISLAND

	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Age						
< 65	27	70.4	88.5	26.9	3.8	11.5
65-74	40	62.5	72.5	25.0	15.0	5.0
75-84	46	43.5	63.0	39.1	19.6	6.5
85+	20	30.0	50.0	25.0	15.0	35.0
		p<.05	p<.05	NS	NS	p<.01
b) Marital status						
Single	10	40.0	50.0	60.0	0.0	20.0
Married	38	65.8	81.6	15.8	13.2	7.9
Widowed	61	49.2	71.7	33.3	16.7	15.0
Divorced or separated	16	50.0	68.8	31.3	12.5	6.3
		NS	NS	p<.05	NS	NS
c) Physical health						
A recent decline	79	46.8	64.1	34.6	21.8	14.1
No recent delcine	51	60.8	76.5	23.5	3.9	5.9
		NS	NS	NS	p<.01	NS
d) Mental health status						
Excellent	1	100.0	100.0	0.0	0.0	0.0
Good	27	37.0	59.3	40.7	22.2	18.5
Poor	71	57.2	82.9	32.9	7.1	8.6
		NS	p<.05	NS	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

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TABLE 4.26 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY PERPETRATOR'S PSYCHOLOGICAL STATUS* - RHODE ISLAND

Psychopathology Status	All Cases	Physical Abuse	Psychological Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) History of mental illness						
No	75	44.0	68.0	28.0	18.7	16.0
Yes	43	74.4	83.3	28.6	7.1	4.8
		p<.01	NS	NS	NS	NS
b) Mental health changes						
A recent decline	40	75.0	76.9	17.9	12.8	7.7
No recent decline	86	44.2	67.4	33.7	14.0	12.8
		p<.01	NS	NS	NS	NS
c) Provocative behavior						
A recent increase	80	65.0	77.2	25.3	15.2	6.3
No recent increase in	46	34.8	58.7	34.8	10.9	19.6
		p<.01	p<.05	NS	NS	p<.05

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

of those perpetrators who had evidenced an increase in provocative behavior were involved in acts of physical abuse whereas for those not evidencing this behavior the occurrence was 34.8 percent.

The rate of psychological abuse was also higher (77.2 percent) in cases where perpetrators had become more provocative than in those cases where provocation had not increased (58.7 percent). Although the history and present psychological status of perpetrators was not significantly related to acts of psychological abuse, higher rates were present in cases where perpetrators evidenced poorer mental health. The presence or absence of provocative behavior by the perpetrator was a significant factor also, in cases of passive neglect. Higher rates of passive neglect (19.6 percent) were found, however, in cases where provocative behavior was absent, compared to cases where it was present, 6.3 percent. The psychological status of perpetrators was unrelated to cases of material abuse and active neglect.

Dependency Status of the Victims

Health status. The physical health of elderly victims was a significant factor only in cases of active neglect, while the mental health of victims was only related to cases of psychological abuse (See Table 4.25). A higher rate of active neglect (21.8 percent) was found in those cases where victims had suffered a recent decline in physical health compared to 3.9 percent in those whose physical health had remained stable. Psychological abuse occurred at a higher rate (82.9 percent) when the victim's mental health was considered "poor," in contrast to 59.3 percent when it was perceived as "good." Only in one abuse/neglect case was the mental health of the elderly victim considered excellent.

Cognitive functioning. As indicated in Table 4.27 the level of cognitive functioning of elderly victims, in terms of the degree of orientation and ability to give consent, is related to the occurrence of psychological abuse and neglect. One measurement of cognitive functioning, related to recent memory, is shown to be a significant factor in cases of physical abuse. However, given the lack of other significant relationships between physical abuse and the other measures of cognitive functioning, and the similar rates of occurrence in those with an ongoing problem (50 percent) and those with an absence of a problem (61.9 percent) with recent memory, this finding is probably not of any theoretical importance. With respect to psychological abuse, it can be seen that this type of perpetration occurs at its highest rate (approximately four out of five) in cases where victims are the least dysfunctional on all variables measuring cognitive functioning. Cases of neglect seem related to the presence of at least some degree of cognitive impairment in the elderly victims, with a greater impairment being found in cases of passive neglect. Active neglect appears to be associated to a victim's periodic disorientation with respect to person and place and an inability to give consent.

Just over 30 percent of all cases with these indications of cognitive functioning are victims of active neglect in comparison with a rate of between 7 percent and 10 percent for those elderly victims with no

TABLE 4.27 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S COGNITIVE STATUS - RHODE ISLAND

Cognitive Status	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Orientation to person:						
On-going problem	6	16.7	50.0	33.3	33.3	50.0
Intermittent problem	13	46.2	61.5	46.2	15.4	84.6
No problem	33	48.5	88.6	42.9	11.4	22.9
		NS	p<.05	NS	NS	p<.001
b) Orientation to place:						
On-going problem	6	16.7	50.0	33.3	33.3	50.0
Intermittent problem	8	37.5	50.0	62.5	25.0	75.0
No problem	37	48.6	84.6	38.5	10.0	30.8
		NS	p<.05	NS	NS	NS
c) Orientation to time:						
On-going problem	8	37.5	50.0	25.0	25.0	75.0
Intermittent problem	9	22.2	60.0	60.0	20.0	60.0
No problem	34	47.1	85.7	40.0	11.4	28.6
		NS	p<.05	NS	NS	p<.05
d) Immediate memory:						
On-going problem	8	37.5	50.0	25.0	25.0	75.0
Intermittent problem	6	16.7	50.0	66.7	33.3	66.7
No problem	33	45.5	88.2	44.1	11.8	29.4
		NS	p<.05	NS	NS	p<.05
e) Recent memory:						
On-going problem	8	37.5	50.0	25.0	25.0	75.0
Intermittent problem	9	22.2	60.0	50.0	20.0	70.0
No problem	27	48.1	92.6	48.1	11.1	18.5
		NS	p<.05	NS	p<.05	p<.05
f) Remote memory:						
On-going problem	5	20.0	40.0	20.0	40.0	60.0
Intermittent problem	7	28.6	57.1	71.4	0.0	85.7
No problem	25	48.0	84.0	52.0	12.0	20.0
		NS	NS	NS	NS	p<.01
g) Ability to consent:						
Can give consent	38	50.0	85.0	40.0	10.0	32.5
Cannot give consent	9	33.3	33.3	11.1	33.3	66.7
		NS	p<.01	NS	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

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such problems. Elderly victim's orientation status with respect to person, place and time, and their immediate and recent memory were all directly related to the relative frequency of passive neglect. The rates of passive neglect in those cases where victims had none of the above problems ranged from 5.8 to 4.5 percent while the corresponding rates in cases where elders had on-going difficulties ranged from 30 to 21.4 percent.

Impairment status. Only in cases of active neglect (see Table 4.28), is the number of impairments of an elderly victim, which require intervention by caseworkers, a significant factor. In general terms, the rate of this type of perpetration is higher for elderly victims with more than three impairments than it is for those with three or less. Specifically, the highest rates occur for those elders with three (31.0 percent) or four (28.6 percent) impairments. This compares to 0.0 percent active neglect in all cases where there is an absence of impairments, 14.3 percent for one impairment and 7.1 percent, for two. A specific indicator of an elder's impairment status, his/her need for a supportive device, e.g., wheelchair, is a significant factor in cases of physical abuse and both types of neglect. In cases of active and passive neglect the percentage of neglect is higher when elder victims need such a device. On the other hand, physical abuse occurs at a higher rate if victims do not have a need for a support device. The percentage of active neglect is 19.0 percent in cases where victims need help with their mobility and 3.8 percent in cases where no such need exists. Twenty-six (26.2) percent of all elders who need a support device are victims of passive neglect compared to 1.9 percent of those elders who have no such need. Conversely, the rate of physical abuse is 35.7 percent for elders who need a support device and 58.5 percent for those who do not have this requirement.

Instrumental activities of daily living. As can be seen in Table 4.29 an elder victim's ability to perform instrumental activities of daily living is significantly related, in varying ways, to all types of abuse and neglect. Generally, elders who have a higher degree of functioning are more likely to be victims of physical and psychological abuse, whereas those who have difficulties with these activities are more likely to be victims of active and passive neglect. With respect to material abuse only, a victim's problems with movement and property security are related to its occurrence. The percentages of physical and psychological abuse are lower for elders who have problems with personal care, management of personal affairs, shopping and household management, compared to victims without such problems. In addition, for psychological abuse, its occurrence is significantly lower, on all the remaining indicators of instrumental activity: mobility, meal preparation, security of property and transportation. From 42.5 to 45.7 percent of all physically abused victims had problems with personal care, personal affairs, shopping and household management compared to a range between 61.1 and 64.9 percent for than without problems. Similarly, the percentage of psychological abused victims ranged from 54 and 61 percent for those with problems and from 78 to 86 percent, without.

TABLE 4.28 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S IMPAIRMENT STATUS* - RHODE ISLAND

Impairment Status	All Cases	Physical Abuse	Psychological Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Number of impairments						
0	21	57.1	81.0	33.3	0.0	4.8
1	29	48.3	60.7	21.4	14.3	17.9
2	28	46.4	67.9	39.3	7.1	10.7
3	29	51.7	58.6	34.5	31.0	10.3
4	7	71.4	85.1	57.1	28.6	0.0
5	8	50.0	100.0	25.0	12.5	12.5
		NS	NS	NS	$p<.05$	NS
b) Needs support devices						
Yes	42	35.7	66.7	35.7	19.0	26.2
No	53	58.5	77.4	28.3	3.8	1.9
		$p<.05$	NS	NS	$p<.05$	$p<.001$

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

TABLE 4.29 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S PROBLEMS WITH INSTRUMENTAL ACTIVITIES OF DAILY LIVING* - RHODE ISLAND

Instrumental Activities	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Personal care						
Problem	73	42.5	54.8	34.2	24.7	19.2
No problem	57	64.9	85.7	25.0	1.8	0.0
		$p<.05$	$p<.001$	NS	$p<.001$	$p<.001$
b) Mobility						
Problem	75	45.3	57.3	37.3	21.3	18.7
No problem	54	61.1	83.0	20.8	5.7	0.0
		NS	$p<.01$	$p<.05$	$p<.05$	$p<.001$
c) Meal preparation						
Problem	73	45.2	57.5	34.2	23.3	20.0
No problem	57	61.4	83.9	25.0	3.6	0.0
		NS	$p<.01$	NS	$p<.01$	$p<.001$
d) Safety of property						
Problem	75	45.3	60.8	37.8	23.0	17.6
No problem	51	62.7	78.4	17.6	2.0	2.0
		NS	$p<.05$	$p<.05$	$p<.01$	$p<.01$
e) Management of personal affairs						
Problem	69	43.5	59.4	37.7	24.6	15.9
No problem	59	62.7	79.3	22.4	1.7	6.9
		$p<.05$	$p<.05$	NS	$p<.001$	NS
f) Shopping						
Problem	82	45.1	59.8	35.4	22.0	17.1
No problem	47	63.8	84.8	21.7	0.0	2.2
		$p<.05$	$p<.01$	NS	$p<.001$	$p<.05$
g) Transportation						
Problem	81	45.7	60.5	33.3	22.2	17.3
No problem	48	62.5	83.0	25.5	2.1	2.1
		NS	$p<.01$	NS	$p<.01$	$p<.05$
h) Household management						
Problem	80	43.8	60.0	36.3	23.0	17.5
No problem	51	64.7	82.0	22.0	0.0	2.0
		$p<.05$	$p<.01$	NS	$p<.001$	$p<.01$

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The percentages of active and passive neglect are significantly higher for elders who have problems with instrumental activities. This relationship holds for every indicator of this dimension with the exception of the relationship between passive neglect and the management of personal affairs. The percentage of active neglect ranged from 21.3 to 24.7 percent in those cases where elders have problems, and from 0.0 percent and 5.7 percent in those cases where there are no such problems. For all significant variables, the percentage of passive neglect ranged from 17.1 to 20.0 percent in those cases where clients had problems with the activity compared to an occurrence between 0.0 percent and 2.2 percent in cases where such problems were absent.

Concerning the two indicators of instrumental activity significantly related to material abuse, the rate of occurrence was 37.3 percent if victims had problems with mobility and 37.8 percent if they had problems with the security of their property in contrast to rates of 20.8 and 17.6 percent, respectively, when these problems were absent.

Specific dependencies. Table 4.30 depicts the relationships between specific dependencies of elderly victims to each type of abuse and neglect. In general terms, it can be seen that higher rates of physical and psychological abuse are found in cases where victims are relatively independent, whereas higher rates of active and passive neglect occur when the elderly are relatively dependent. Material abuse is not related to any of the selected dependencies.

In cases of physical and psychological abuse, rates of occurrence were significantly lower when victims were perceived to have become increasingly dependent, prior to acts of maltreatment, compared to the rates for those victims whose dependency needs had remained stable (61.9 percent) the rates of physical abuse were 43.3 percent of dependency needs had increased and 61.9 percent if they had remained stable. The comparable rates for psychological abuse were 60.6 and 77.8 percent. Regarding specific dependencies, transportation and daily needs (e.g., meals and medications) were significant factors in cases of physical abuse. Of those victims who were independent for their transportation needs, 62.7 percent were abused physically. This compares to 39.6 percent for those who were very dependent. Sixty-six (66.1) percent of the victims who were independent for their daily needs were physically abused, compared to 38.5 percent of those who were very dependent. Dependencies related to financial management, transportation, daily needs and property maintenance were inversely related, also, to cases of psychological abuse. The percentage of such abuse was over 80 percent in cases where victims were independent for the above needs and ranged from 49 to 61 percent when victims were very dependent.

The occurrence of passive neglect was significantly higher (16.7 percent) for those victims whose general dependency needs had increased prior to the perpetration, compared to those whose dependency status was unchanged (4.8 percent). Concerning specific dependencies, financial management, transportation, daily needs and property maintenance were contributing factors to both active and passive neglect, with companionship needs being significant in the latter cases. For all variables,

TABLE 4.30 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM'S DEPENDENCY STATUS* - RHODE ISLAND

Dependency Status	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Increased dependency						
Yes	67	43.3	60.6	33.3	19.7	16.7
No	63	61.9	77.8	27.0	9.5	4.8
		p<.05	p<.05	NS	NS	p<.05
b) Financial management						
Independent	70	58.6	82.6	31.9	5.8	5.8
Slightly dependent	13	53.8	69.2	38.5	30.8	0.0
Very dependent	37	40.5	48.6	32.4	21.6	24.3
		NS	p<.01	NS	p<.05	p<.01
c) Companionship						
Independent	33	60.6	81.3	40.6	3.1	3.1
Slightly dependent	15	33.3	80.0	20.0	20.0	0.0
Very dependent	76	52.6	63.2	28.9	18.4	18.4
		NS	NS	NS	NS	p<.05
d) Transportation						
Independent	51	62.7	84.0	34.0	4.0	2.0
Slightly dependent	8	75.0	75.0	37.5	25.0	0.0
Very dependent	53	39.6	60.4	30.2	20.8	24.5
		p<.05	p<.05	NS	p<.05	p<.01
e) Daily needs						
Independent	56	66.1	85.7	28.6	1.8	1.8
Slightly dependent	14	53.3	71.4	35.7	14.3	0.0
Very dependent	52	38.5	55.8	28.8	28.8	26.9
		p<.05	p<.01	NS	p<.001	p<.01
f) Property maintenance						
Independent	41	61.0	85.4	31.7	2.4	2.4
Slightly dependent	12	58.3	83.3	50.0	8.3	0.0
Very dependent	51	47.1	60.8	27.5	23.5	23.5
		NS	p<.05	NS	p<.05	p<.01

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the incidence of cases was lowest when victims were independent, ranging from 1.8 percent to 5.8 percent compared to 18.4 to 28.8 percent for the rates of active and passive neglect in cases where victims were very dependent.

Dependency Status of Perpetrators

With respect to the dependencies of perpetrators, there was no significant relationship between the presence or absence of an increase in their overall dependencies on victims, and the rates of any type of abuse or neglect. However, a perpetrator's dependency on a victim for finances was a significant factor ($p<.05$) in cases of material abuse. The proportion of victims of material abuse were 46.3 percent if perpetrators were very dependent, 16.7 percent if they were slightly dependent and 11.8 percent if they were independent financially.

Relationship dynamics between perpetrators and victims. As shown in Table 4.31, the relationship of a perpetrator to an elder client was a significant factor in cases of psychological and material abuse, but not related to other types of abuse and neglect. The rate of psychological abuse was apt to be highest when perpetrators were sons or spouses. For husbands, the percentage of psychological abuse was 87.5 percent, sons 86.0 percent; non relatives, 47.6 percent; siblings and other relatives 50.0 percent; wives, 66.7 percent; and daughters, 66.7 percent. The highest rates of material abuse, however, involved perpetrators who were either distant relatives or non-relatives (57.1 percent in both cases). The rates were 25.6 percent for sons, 16.7 percent for daughters and siblings, 12.5 percent for husbands and 0.0 percent for wives.

The perception of the quality of the relationship of the victim and perpetrator was a significant factor ($p<.01$) only in cases of passive neglect. The percentage of this type of neglect was highest when the relationship between the two parties was seen as "excellent" (33.3 percent) and lowest when the relationship was "poor" (4.9 percent).

External Stress

Table 4.32 indicates the impact of externally induced stress experienced by perpetrators which might contribute to an act of abuse or neglect. None of these factors were related to the occurrence of physical abuse. Rates of psychological abuse were higher if perpetrators had experienced a recent change in their living situation (90.5 percent) and lower (66.3 percent) in the absence of a change. The percentage of psychological abuse was lowest (70.8 percent) when the stresses imposed by the needs and behaviors of elders were perceived as greatest in contrast to a rate of psychological abuse of 90.5 percent when the victim was perceived as not being a source of stress.

Long-term financial problems experienced by perpetrators were a significant factor in cases of material abuse. On the other hand, rates of material abuse were significantly lower when external stress, imposed by divorce/separation and the victim's provocative behavior, were experienced by perpetrators. Material abuse occurred in 43.5 percent of

TABLE 4.31 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY RELATIONSHIP OF PERPETRATOR TO VICTIM* - RHODE ISLAND

Perpetrator Relationship	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
Husband	16	62.5	87.5	12.5	6.3	12.5
Wife	6	66.7	66.7	0.0	33.3	16.7
Son	44	59.1	86.0	25.6	7.0	11.6
Daughter	24	45.8	70.8	16.7	20.8	16.7
Siblings	6	100.0	50.0	16.7	16.7	16.7
Other relative	14	42.9	50.0	57.1	28.6	7.1
Non-relative	21	33.3	47.6	57.1	14.3	4.8
		NS	$p < .05$	$p < .01$	NS	NS

*Row totals do not add up to 100 because of multiple manifestations of abuse/neglect in single cases.

TABLE 4.32 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY EXTERNAL STRESSES ON PERPETRATORS* - RHODE ISLAND

External Stress	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Long-term financial problems						
Yes	46	60.9	78.3	43.5	17.4	2.2
No	72	51.4	70.4	18.3	12.7	18.3
		NS	NS	p<.05	NS	p<.001
b) Recent change in job/financial problems						
Yes	30	60.0	72.4	37.9	20.7	0.0
No	96	52.1	69.8	26.0	11.5	14.6
		NS	NS	NS	NS	p<.05
c) Recent divorcing or separation						
Yes	16	62.5	86.7	6.7	20.0	13.3
No	102	53.9	71.6	31.4	13.7	11.8
		NS	NS	p<.05	NS	NS
d) Recent change in living situation						
Yes	21	66.7	90.5	23.8	14.3	4.8
No	105	51.4	66.3	29.8	13.5	12.5
		NS	p<.05	NS	NS	NS
e) Victim's provocative behavior						
Yes	9	77.8	77.8	0.0	11.1	0.0
No	121	50.4	68.3	32.5	15.0	11.7
		NS	NS	p<.05	NS	NS

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all cases where perpetrators had long-term financial problems, compared to a rate of 18.3 percent when this problem was absent. In cases where victims were provocative the rate of material abuse was 0.0 percent compared to 32.5 percent when provocative behavior was absent. The percentage of material abuse was 6.7 percent for recently divorced or separated perpetrators and 31.4 percent for those who had not been subjected to this experience.

Active neglect occurred when elderly victims were seen as a major source of stress to the perpetrator. When the imposed stress was seen as "a lot," the rate of active neglect was 27.1 percent, whereas such neglect was absent in cases where victims were seen as either "a little" or "not at all" a source of stress.

Passive neglect occurred at a significantly higher rate in cases where potential stresses caused by long and short-term financial and job related problems were absent. The percentage of passive neglect was 18.3 percent of all cases where long-term financial problems were absent, compared to 2.2 percent when such problems were present. The rate of passive neglect was 14.6 percent for all perpetrators who had not experienced recent job or financial problems, and 0.0 percent when such problems had been experienced.

Social Networks and Isolation

The living situation and social network of elderly victims was a factor in all cases of abuse/neglect (Table 4.33). The rates of physical abuse were significantly higher when victims lived with others, which in 100 out of 102 cases included their perpetrator. The percentage of physical abuse was 59 percent when the two lived together and 33.3 percent when they lived apart. Other factors, related to recent losses in victims' support networks, changes in family relationships and the presence of an emergency contact, were not significant contributants to physical abuse. The rate of psychological abuse too, was significantly higher when victims resided with others but not to any statistically significant extent did other cohabitors include the abusers. The rate of psychological abuse was 71.2 percent when victims dwelled with others and 51.6 percent when they lived alone. Other factors related to victims' social networks were not related to this type of abuse. Material abuse, on the other hand, occurred at a significantly higher rate when victims lived alone, and, therefore, not suprisingly, when they did not live with their perpetrator. Active neglect was most likely to occur when victims were experiencing a loss in their social network prior to the perpetration, to the extent of not having an emergency contact. Victims who were experiencing losses in their social network were actively neglected at a rate of 25.8 percent compared to 11.2 percent for those not experiencing losses. For those who had no identified emergency contact the percentage of active neglect was 33.3 percent compared to 10.4 percent for those who had a contact. Passive neglect was indirectly related to victims' experiencing recent changes in family relationships. For those victims who had not suffered a change in family relationships the percentage of passive neglect was 14.9 percent compared to 0.0 percent for those who had experienced a change.

TABLE 4.33 PERCENT OF TOTAL CASES BY ABUSE/NEGLECT TYPE BY VICTIM AS A SOURCE OF STRESS AND VICTIM'S SOCIAL NETWORK - RHODE ISLAND

Social Network	All Cases	Physical Abuse	Psycho-logical Abuse	Material Abuse	Active Neglect	Passive Neglect
	#	%	%	%	%	%
a) Living situation,						
Lives alone	31	32.3	51.6	51.6	16.1	6.5
Lives with others	102	58.8	71.2	23.8	13.9	12.9
		$p<.01$	$p<.05$	$p<.01$	NS	NS
b) Victims-perpetrator						
Lives together	100	59.0	73.7	21.2	14.1	13.1
Live apart	30	33.3	56.7	60.0	13.3	6.7
		$p<.05$	NS	$p<.01$	NS	NS
c) Recent loss of supports						
Yes	32	46.9	61.3	38.7	25.8	12.9
No	98	54.1	71.4	27.6	11.2	10.2
		NS	NS	NS	$p<.05$	NS
d) Recent change in family relationship						
Yes	35	57.1	71.4	31.4	22.9	0.0
No	95	50.5	68.1	29.8	11.7	14.9
		NS	NS	NS	NS	$p<.05$
e) Emergency contact						
Yes	107	52.3	69.8	33.0	10.4	12.3
No	9	66.7	77.8	33.3	33.3	11.1
		NS	NS	NS	$p<.05$	NS

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B. Discussion

From the previous examination of the Rhode Island data, some general statements can be made about the characteristics of each type of abuse and neglect, particularly with respect to the contribution of the factors under investigation, i.e., characteristics of perpetrators, external stresses, social isolation and dependency and exchange relationships. Passive and active neglect seem very clearly related to the dependency needs of elderly victims, as an outcome of their impairments. Elderly victims in neglect situations tend to have problems with cognitive functioning and the performance of instrumental activities of daily living. Victims of active neglect have intermittent problems with respect to their orientation towards people and place, whereas these problems are more continuous in passive neglect cases. In the latter situation the elders, also, are likely to be somewhat disoriented towards time and as have problems with immediate and recent memory. Victims of active neglect have significant problems too, with their ability to give consent.

Elderly people who are victims of either active or passive neglect are very impaired with respect to their ability to perform instrumental activities of daily living. They are likely to require support devices and have significant problems with personal care, movement, meal preparation, safety of property, shopping, transportation and household management. A significant number of actively neglected elders have suffered a recent decline in physical health, reflected in their having a high number of impairments. Because of their impaired functioning, victims of neglect are dependent on their caretaker for financial management, transportation, daily needs (e.g., meal preparation, medications) and property maintenance. In addition, the dependency needs of victims of passive neglect tended to increase prior to the perpetration, probably because of the relatively high percentage over 85 years. They also are more apt to be dependent on perpetrators for companionship.

Victims of active neglect tend to be relatively isolated, experiencing recent losses in their social network, and, in a significant number of cases are without an emergency contact. Because of their impairments and dependencies, including an increased need for companionship from their caretakers, victims of active neglect are seen as a source of stress to the perpetrators. In summary then, neglect, in large part, is linked to the dependency needs of the elderly victims of active neglect cases are viewed as additionally burdensome because of their relative isolation.

Elderly victims of psychological abuse tend to be relatively young, and unimpaired with respect to physical health, cognitive functioning and their ability to perform instrumental activities of daily living. Significantly higher rates of psychological abuse were found in cases where elderly victims did not have problems with all of the measures of cognitive functioning and instrumental activity. It is not surprising, therefore, that such elders were not seen as dependent on their perpetrators. The highest rates of psychological abuse occurred in cases where victims were independent with respect to financial management, transportation, daily needs and property maintenance.

A significantly higher rate of psychological abuse involving family members who are most intimately related, i.e., spouses and adult children, indicates that pathological family and interpersonal dynamics are involved in these cases. This postulate is supported by the significantly higher rates of psychological abuse in cases where perpetrators have become increasingly more provocative in their behavior towards victims, and the fact that a significant number of victims are said to be in "poor" mental health. A focus on the emotional and mental status of participants and its impact on the relationship between the two parties may well be the avenue to pursue to generate an understanding of psychological abuse. Certainly it is likely that given the intimacy of the relationships involved, the provocative behavior of the perpetrator and the poor mental health status of the victim, the relationship between the two will involve pathological interpersonal dynamics.

Material abuse seems best understood by focusing on the financial stresses on the perpetrator and the relative vulnerability of the victim. A significantly higher percentage of material abuse occurs in cases where perpetrators have long-term financial problems. There is also a relative isolation of victims and potential vulnerability because of their marital status. A significantly high proportion of victims of elder abuse are single and therefore more prone to abuse. Factors related to the physical and mental status of perpetrators and victims, and the cognitive, functional and dependency status of the victim appear relatively unimportant in these cases. The fact that a significantly high proportion of material abuse involves distant relatives or parties who are unrelated by birth or marriage, who do not live together, lends support to the idea that financial gain rather than interpersonal pathology is the most important factor in material abuse.

Physical abuse seems very closely linked to the mental health of the perpetrator. A significantly high proportion of perpetrators of physical abuse have a history of mental illness, have suffered a recent decline in mental health, and have become increasingly provocative prior to the perpetration. The living situation in these cases probably contributes also to the occurrence of physical abuse since a significantly high percentage of perpetrators and victims live together. Factors related to the impairment and dependency status of the victim do not seem to be all that important in these cases. They appear to have a high level of cognitive functioning and ability to perform instrumental activities of daily living. In fact in many instances, the highest rates of physical abuse occur when victims do not have problems with their cognitive or functional abilities.

IV. Conclusion

A review of the data and analyses at the three sites does permit some postulates to be forwarded concerning factors which appear to be related to each type of elderly abuse and neglect (See Figure 2 for a summary of significant findings). Specifically, tentative generalizations can be made concerning the applicability of four theoretical frameworks to each type of abuse and neglect. These theoretical frameworks focus on: a) the intra-individual attributes of participants, particularly the mental and emotional health of perpetrators; b) the nature and dynamics of exchange relationships, focusing specifically on the impact the victims' dependencies have on relationships with perpetrators; c) the impact of external stresses on both perpetrators and victims; d) the role of social isolation.

Concerning active and passive neglect, findings at the three sites suggest, clearly, that neglect is related to the dependency needs of elderly victims. Victims of neglect have significant problems with cognitive functioning and performance of instrumental activities of daily living. As an outcome of these impairments, victims find themselves dependent on their caretakers for many activities of daily living. Given these findings, exchange theory may well provide an appropriate theoretical underpinning to cases of neglect. The exchange paradigm suggests that as dependencies increase, the costs of the relationship grow to the caregiver, the rewards diminish and the exchange becomes perceived as unfair.

Passive neglect appears to have a more benign quality compared to cases of active neglect, because of its tendency to involve extenuating circumstances, although comparisons could only be made between Syracuse and Rhode Island. Victims of passive neglect are likely to be more burdensome and stressful because of their tendency to one or more of the following attributes - older age, greater degree of impairment, tendency to be seen as a source of stress, or a recent decline in mental health. In addition, perpetrators of passive neglect in the Syracuse sample were already stressed by their own lives and a significant likelihood that they had suffered a recent divorce or separation. A tendency towards social isolation, associated with such a loss, was a factor also in cases of passive neglect in Worcester where a significant number of perpetrators were without an emergency contact.

Psychological abuse provides a marked contrast to cases of neglect. Victims of psychological abuse are relatively unimpaired, with respect to their cognitive and functional status and relatively independent for their daily needs. Psychological abuse appears to be related to the mental health of participants and pathological interpersonal dynamics in the exchanges between the victim and perpetrator. It may well be that pathological, psychological interdependencies are an important factor in these cases, caused in part, by the emotional status of both parties. In both Rhode Island and Worcester, the mental health of victims of psychological abuse was characterized as "poor." In Rhode Island perpetrators were likely to be provocative in their behavior towards the elderly victims of such abuse and, in Syracuse, they were seen as having unrealistic expectations of the elder in relationships that were

Figure 2 Summary of Type of Relationships by Type of Abuse for Worcester (W), Syracuse (S) and Rhode Island (R)

Variables included in the Analyses	Physical Abuse			Psychological Abuse			Material Abuse			Active Nelgect			Passive Neglect		
	W	S	R	W	S	R	W	S	R	W	S	R	W	S	R
1. Sociodemography of victim:															
age			*			*									*
sex															
marital status									*						
income				*							*				
2. Sociodemography of perpetrator:															
age		*					*	*							
sex									*						*
income															
3. Impairments of perpetrator:															
a) psychological:															
history of mental illness			*												
previous suicide attempts															
recent decline in mental health	*	*	*										*		
alcohol abuse								*							
drug abuse															
provocative behavior			*			*							*		*
previous institutionalization				INSUFFICIENT DATA											
b) physical:															
long term problems					*										
short term problems		*			*										
recent decline in health		*			*		*	*							

Figure 2 Summary of Type of Relationships by Type of Abuse for Worcester (W), Syracuse (S) and Rhode Island (R) (cont.)

Variables included in the Analyses	Physical Abuse			Psychological Abuse			Material Abuse			Active Neglect			Passive Neglect		
	W	S	R	W	S	R	W	S	R	W	S	R	W	S	R
4. Impairments of victim:															
a) psychological:															
recent decline in mental health				*									*	*	
self esteem rating															
emotional status rating				*		*									
provocative behavior	*						*		*						
previous institutionalization				INSUFFICIENT DATA											
b) physical:															
recent decline in physical health												*			
number of impairments												*			
need for support device			*							*		*		*	*
c) cognitive functioning problems:															
orientation to person				*	*	*						*	*	*	*
orientation to place				*	*	*						*		*	*
orientation to time				*	*	*					*		*	*	*
immediate memory				*	*	*							*		*
recent memory			*	*	*	*				*			*		
remote memory					*	*							*		
ability to give consent				*	*	*						*			

Figure 2 Summary of Type of Relationships by Type of Abuse for Worcester (W), Syracuse (S) and Rhode Island (R) (cont.)

Variables included in the Analyses	Physical Abuse			Psychological Abuse			Material Abuse			Active Neglect			Passive Neglect		
	W	S	R	W	S	R	W	S	R	W	S	R	W	S	R
d) problems with instrumental activities of daily living:															
personal care			*	*	*	*					*	*	*	*	*
mobility						*			*			*		*	*
meal preparation				*		*						*	*		*
security of property					*	*			*		*	*			*
management of personal affairs			*		*	*					*	*		*	
shopping			*			*						*	*		*
transportation						*						*		*	*
household management	*		*	*	*	*					*	*	*	*	*
e) Victim dependency issues:															
recent increase in overall dependency on perpetrator			*			*									*
dependent on perpetrator for:															
financial resources		*									*				
financial management			*	*	*						*	*	*		*
companionship		*		*				*					*		*
transportation			*	*	*	*	*				*	*	*	*	*
daily needs			*	*	*	*					*	*	*	*	*
property maintenance				*		*						*	*	*	*

Figure 2 Summary of Type of Relationships by Type of Abuse for Worcester (W), Syracuse (S), and Rhode Island (R) (cont.)

Variables included in the Analyses	Physical Abuse			Psychological Abuse			Material Abuse			Active Neglect			Passive Neglect		
	W	S	R	W	S	R	W	S	R	W	S	R	W	S	R
5. Perpetrator dependency status:															
recent increase in overall dependency	*												*	*	
finances								*	*						
companionship															
activities of daily living															
6. Victim-perpetrator relationship:															
nature of relationship		*				*	*	*	*	*					
assessed quality of relationship					*								*		*
perpetrator's unrealistic expectations				*	*										
7. External stresses on perpetrator:															
victim as a source of stress		*				*		*				*			
recent death of spouse														*	
recent divorce/separation								*	*						
recent birth of child															
long term financial problems								*	*						*
short term financial problems				*				*					*		
recent change in financial/job status								*							*
recent change in living arrangements						*									*

Figure 2 Summary of Type of Relationship by Type of Abuse for Worcester(W), Syracuse (S), and Rhode Island (R) (cont.)

Variables included in the Analyses	Physical Abuse			Psychological Abuse			Material Abuse			Active Neglect			Passive Neglect		
	W	S	R	W	S	R	W	S	R	W	S	R	W	S	R
8. External stresses on victim:															
recent change in financial/job status															
recent change in living arrangements		*						*						*	
recent change in family relationships															*
9. Social supports of victim:															
lives alone	*	*	*			*	*		*						
lives with perpetrator	*	*	*			*	*			*					
number of social contacts					*										
frequency social contacts							*								
recent loss of supports		*						*				*		*	
emergency contact available					*						*			*	
10. Social supports of perpetrator:															
recent loss of supports							*								
emergency contact available												*	*		
family available for support	*								*						

Figure 2 Summary of Type of Relationships by Type of Abuse for Worcester (W), Syracuse (S) and Rhode Island (R) (cont.)

Variables included in the Analyses	Physical Abuse W S R	Psychological Abuse W S R	Material Abuse W S R	Active Neglect W S R	Passive Neglect W S R
11. Individual and Family History:					
victim from unstable background		INSUFFICIENT DATA			
perpetrator from unstable background		INSUFFICIENT DATA			
perpetrator as a victim of child abuse		INSUFFICIENT DATA			
other acts of abuse by perpetrators		INSUFFICIENT DATA			

* indicates relationships which are statistically significant at the $P < .05$ level.

characterized as "poor" in a significant number of cases. In sum, then exchange theory seems applicable to cases of psychological abuse.

Unlike cases of neglect, however, victims of psychological abuse are more likely to be impaired emotionally rather than cognitively or functionally. Also, transactions between victims and perpetrators are likely to involve pathological behavior by the latter. As a matter of fact, a tendency at one site, for perpetrators to have unrealistic expectations suggest that some psychological dependency on the elderly victim may exist. Indirectly, this finding is supported at a second site where a significant number of perpetrators of psychological abuse were provocative in their behavior towards their victims. There is the possibility that, at least in some cases of psychological abuse, perpetrators remain somewhat psychologically dependent on their victims and experience a perceived loss of power in their exchanges, as suggested by Finklehor.

Material abuse seems to be nearly exclusively related to the financial needs of perpetrators, although the determination of a statistically significant relationship in the Worcester cases was not possible because of the small number of cases. The relative social isolation of victims and associated increase in their vulnerability was a likely contributing factor in two sites. In Syracuse cases, victims had suffered recent losses in their social network, and in Rhode Island victims of material abuse tended to be single. Material abuse seems to involve a motivation based on achieving a specific gain, namely, money, by perpetrators who are not too emotionally involved with the victim because of the likelihood that they are more distant relatives or totally unrelated.

The two common denominators in cases of physical abuse in all three sites were the relatively poor mental and emotional status of the perpetrator and the shared residence between victims and perpetrators. The intra-individual attributes of perpetrators, particularly as they relate to their mental health status, and the living situation of elderly victims seem to be crucial factors in cases of physical abuse, and interpersonal pathology as well. At the Syracuse site, cases of physical abuse involved victims who were likely to be seen as a source of stress, and, at Worcester, provocative behavior towards the perpetrators by victims was perceived to be a significant factor. A re-assessment of the abuse/neglect cases at time of closure provides further support for the distinctiveness of each type of abuse. The results of the outcome analyses are given in the next Chapter.

CHAPTER FIVE

OUTCOME ANALYSES

With information drawn from the Case Assessments, it we possible to show in the previous chapter that not only is there a fairly consistent set of factors associated with maltreatment of the elderly among the three Model Projects, but that each type of abuse has a rather distinctive profile. In this Chapter, the findings from the Case Assessments are compared with those of the Case-Reassessments to determine what changes in the abuse or neglect situation took place during the course of "treatment" by the Model Projects and what factors contributed to the resolution of the cases.

I. Case Assessment and Re-Assessment

A. Methodology

Working closely with the Worcester Model Project staff, the Evaluation Team designed a second assessment form labelled Case Reassessment or Outcome Assessment (Appendix I, Exhibit 3) to measure the status of the abuse situation six months after intake and at six month intervals and/or at case closing. Because it often took several weeks to gather the baseline information, it became impractical for the staff to complete more than one re-assessment. Consequently, the form was used at the close of the case, or at the end of project if the case was still active. The average number of months between the initial and outcome assessment was 6.9 (range of one to thirty) for the Worcester case load; 10.7 months (range of two to twenty-seven months) for Syracuse; and 8.8 months for Rhode Island (range of one to twenty-seven months).

As a companion piece to the Case Assessments, the Re-Assessment form repeated the questions on the manifestations of abuse, dependency ratings, mental/emotional status, stress and added items on agency action and case outcome. Data were completed on 309 cases (Worcester, 57; Syracuse, 127; and Rhode Island, 125). There were 19 which could not be re-assessed because they were resolved at the time of intake or involved clients and/or families who refused to see the staff after the initial encounter or who moved to unknown locations or out-of-state.

To analyze the data gathered at two points in time for each case, the Wilcoxon Matched-Pairs Signed-Ranks test was selected. With this procedure, significant change is based not only on the direction of the differences between the pairs but also on the magnitude of the difference. The level of significance adopted for the study was $p < .05$.

B. Results

In keeping with the framework for the presentation of results in earlier chapters, this section begins with the data on type and severity of abuse, followed by findings on dependency needs, impairment status of the victims, and stress, and ends with the barriers to delivery of services.

Characterization of Abuse and Neglect

At the time of the re-assessment, the socialworkers were requested to indicate changes in the severity of the manifestations of abuse and neglect since the previous assessment, noting whether they were "mild", "moderate", "severe," "questionable" or "no longer a problem." If there was no change between the Time 1 and Time 2 assessment, then the Time 1 value was repeated on the re-assessment form. Tables 5.1-5.3 indicate the number of cases for each category of abuse and neglect for the various degrees of severity. In order to simplify the presentation of data, the number of manifestations under each category of abuse (physical, psychological, etc.) was tallied and the total both at Assessment 1 and Assessment 2 recorded as well as the percentage change (Table 5.4).

With regards to physical abuse in the Worcester case load, there was a 53.1 percent drop in the number of manifestations of abuse between the two assessments. Looking more closely at the degree of severity in Table 5.4, it can be seen that of the 32 manifestations of abuse present at intake for the 57 victims, 16 were no longer a problem at the close of case (case re-assessment). There were fewer manifestations marked "severe" and "moderately severe" and more judged as "mild," plus a number which were "no longer a problem". This pattern prevailed for the remaining types of abuse, psychological, material abuse and neglect, which showed 60.1, 63.2, and 56.6 percent reduction in manifestations, respectively.

The results of the Syracuse analysis indicates a similar decrease in severity and number of manifestations, but at a slightly smaller rate than Worcester: 31.7 percent for physical abuse; 45.8 percent for psychological abuse; 45.6 percent for material abuse; and 44.8 percent for neglect. Except in one instance (these psychological manifestations marked "mild"), there were fewer manifestations of abuse at re-assessment than at assessment for all degrees of severity and for all types of abuse and neglect.

Among the Rhode Island cases, there were less "severe" and "moderately severe" manifestations at the second assessment and an increase in "mild" ones, but the total reduction was less than either the Worcester or Syracuse groups: 27.9 percent, physical abuse; 48.5 percent, psychological abuse; 38.5 percent, material abuse; and 24.3 percent, neglect.

Concerning the actual elimination of the problem, the Worcester staff show that 50.0 percent of the initial manifestations of physical abuse were "no longer a problem." For psychological abuse, it was 42.1 percent, material, 31.6 percent; neglect, 37.6 percent. Except for physical abuse manifestations which dropped 76.6 percent, about the same level of achievement is found in the Syracuse records for the forms of maltreatment: psychological, 40.2 percent; material, 35.1; and neglect, 38.5 percent. In both material (59.6 percent) and neglect (55.1 percent) situations, the Rhode Island personnel noted a greater percentage

TABLE 5.1 MANIFESTATIONS OF ABUSE AND NEGLECT AT TIME OF RE-ASSESSMENT WORCESTER

	None	Mild	Moderate	Severe	?	no longer a problem	N/A
	#	#	#	#	#	#	#
Physical Abuse							
Bruises, welts	42	5	1	-	-	8	1
Sprains, dislocations	56	-	-	-	-	-	1
Malnutrition	56	-	-	-	-	-	1
Burns, scalding	54	-	-	1	1	-	1
Abrasions, lacerations	55	-	-	-	-	1	1
Wounds, cuts, punctures	56	-	-	-	-	-	1
Internal injuries	56	-	-	-	-	-	1
Dismemberment	56	-	-	-	-	-	1
Sexually molested	56	-	-	-	-	-	1
Oversedation	55	1	-	-	-	-	1
Hypothermia	56	-	-	-	-	-	1
Bone fractures	53	1	-	1	-	1	1
Skull fractures	56	-	-	-	-	-	1
Direct beatings	52	1	1	-	-	2	1
Forced into NH	56	-	-	-	-	-	1
Tied to bed	56	-	-	-	-	-	1
Tied to chair	56	-	-	-	-	-	1
Other physical confinement against will	56	-	-	-	-	-	1
Other	47	-	4	-	-	4	2
Psychological Abuse							
Verbal assault	27	5	6	4	2	10	3
Threat	32	2	4	6	1	10	2
Intimidation	31	2	5	6	1	9	3
Humiliation	36	1	5	5	-	7	3
Isolation	38	4	2	3	-	7	3
Other	51	-	-	1	-	2	3

TABLE 5.1 MANIFESTATIONS OF ABUSE AND NEGLECT AT TIME OF RE-ASSESSMENT (cont.) - WORCESTER

	None	Mild	Moderate	Severe	?	no longer a problem	N/A
	#	#	#	#	#	#	#
Material Abuse							
Taking possession of money or property	39	2	5	4	1	5	1
Misuse of money or property	41	1	3	5	1	5	1
Other	51	-	1	1	-	2	2
Neglect							
Abandoned	49	1	2	3	-	1	1
Lack of help house cleaning	52	-	1	1	-	2	1
Lack of food	39	6	-	3	-	8	1
Lack of heat	52	-	-	1	-	3	1
Lack of personal care	45	2	2	3	-	4	1
Lack of supervision	41	3	5	2	-	5	1
Lack of support/ companionship	40	4	5	3	-	4	1
Failure to purchase prescribed Rx	54	-	1	-	-	-	2
No false teeth when needed	54	-	-	2	-	-	1
No hearing aid when needed	53	1	-	-	-	1	2
No glasses when needed	52	1	-	2	-	-	2
Failure to provide other prescribed medical services	45	2	2	-	-	7	1
Failure to fulfill other caretaking obligations	39	2	1	4	-	9	2

TABLE 5.2 MANIFESTATIONS OF ABUSE AND NEGLECT AT TIME OF RE-ASSESSMENT SYRACUSE

	None	Mild	Moderate	Severe	?	no longer a problem	N/A
	#	#	#	#	#	#	#
Physical Abuse							
Bruises, welts	78	7	5	1	-	18	18
Sprains, dislocations	98	2	1	1	-	8	8
Malnutrition	98	-	1	-	-	11	8
Burns, scalding	105	1	-	-	-	4	17
Abrasions, lacerations	103	3	-	-	-	4	17
Wounds, cuts, punctures	106	-	1	-	-	3	17
Internal injuries	109	-	-	-	-	1	17
Dismemberment	109	-	-	-	-	1	17
Sexually molested	106	-	-	1	-	3	17
Oversedation	108	-	-	-	-	2	17
Hypothermia	109	-	-	-	-	4	17
Bone fractures	108	-	-	-	-	2	17
Skull fractures	108	1	-	-	-	1	17
Direct beatings	103	-	2	-	-	5	17
Forced into NH	109	-	-	-	-	4	17
Tied to bed	108	-	-	-	-	2	17
Tied to chair	108	1	-	-	-	1	17
Other physical confinement against will	95	4	1	2	-	9	16
Other	97	2	1	-	-	9	18
Psychological Abuse							
Verbal assault	53	13	8	12	-	25	8
Threat	65	10	8	5	-	23	16
Intimidation	41	17	9	12	-	32	16
Humiliation	46	16	8	9	-	33	15
Isolation	35	17	11	13	1	34	16
Other	100	2	-	-	1	4	20

TABLE 5.2 MANIFESTATIONS OF ABUSE AND NEGLECT AT TIME OF RE-ASSESSMENT (cont.) - SYRACUSE

	None	Mild	Moderate	Severe	?	no longer a problem	N/A
	#	#	#	#	#	#	#
Material Abuse							
Taking possession of money or property	70	5	6	8	1	16	21
Misuse of money or property	52	7	12	9	-	24	23
Other	100	-	2	-	2	-	23
Neglect							
Abandoned	100	2	2	2	-	6	15
Lack of help house cleaning	82	2	9	5	-	14	15
Lack of food	63	5	8	6	1	28	16
Lack of heat	100	1	2	1	-	8	15
Lack of personal care	68	6	9	6	-	22	16
Lack of supervision	66	7	11	7	-	20	16
Lack of support/ companionship	42	7	18	11	2	29	18
Failure to purchase prescribed Rx	89	2	7	4	-	10	15
No false teeth when needed	103	1	3	3	-	2	15
No hearing aid when needed	107	2	1	-	-	2	15
No glasses when needed	103	4	1	1	-	3	15
Failure to provide other prescribed medical services	78	2	7	5	1	18	16
Failure to fulfill other caretaking obligations	65	4	9	9	9	14	17

TABLE 5.3 MANIFESTATIONS OF ABUSE AND NEGLECT AT TIME OF RE-ASSESSMENT RHODE ISLAND

	None	Mild	Moderate	Severe	?	no longer a problem	N/A
	#	#	#	#	#	#	#
Physical Abuse							
Bruises, welts	91	-	2	1	-	17	14
Sprains, dislocations	110	-	-	1	-	-	14
Malnutrition	110	-	1	-	-	-	14
Burns, scalding	107	-	-	-	-	4	14
Abrasions, lacerations	107	-	1	1	-	2	14
Wounds, cuts, punctures	110	-	-	-	-	1	14
Internal injuries	110	-	-	-	-	1	14
Dismemberment	111	-	-	-	-	-	14
Sexually molested	109	-	1	-	-	1	14
Oversedation	111	-	-	-	-	-	14
Hypothermia	111	-	-	-	-	-	14
Bone fractures	105	-	-	-	-	5	15
Skull fractures	110	-	-	-	-	1	14
Direct beatings	90	-	-	7	-	13	15
Forced into NH	111	-	-	-	-	-	14
Tied to bed	110	-	-	-	-	-	15
Tied to chair	110	-	-	-	-	-	15
Other physical confinement against will	103	-	1	2	-	5	14
Other	75	2	6	3	2	22	15
Psychological Abuse							
Verbal assault	24	12	9	17	-	30	33
Threat	38	5	4	18	-	25	35
Intimidation	32	9	6	20	-	24	34
Humiliation	45	7	5	14	-	17	37
Isolation	65	4	4	7	-	5	40
Other	71	1	1	2	1	7	42

TABLE 5.3 MANIFESTATIONS OF ABUSE AND NEGLECT AT TIME OF RE-ASSESSMENT (cont.) - RHODE ISLAND

	None	Mild	Moderate	Severe	?	no longer a problem	N/A
	#	#	#	#	#	#	#
Material Abuse							
Taking possession of money or property	39	1	1	6	1	13	64
Misuse of money or property	44	2	1	2	1	10	65
Other	46	-	3	1	1	8	66
Neglect							
Abandoned	57	-	-	-	-	5	63
Lack of help house cleaning	42	1	-	4	-	15	63
Lack of food	42	2	3	-	-	16	62
Lack of heat	54	1	-	1	-	6	63
Lack of personal care	40	2	1	3	-	16	63
Lack of supervision	41	2	1	4	1	14	62
Lack of support/ companionship	45	-	1	6	-	9	64
Failure to purchase prescribed Rx	59	1	-	-	-	4	63
No false teeth when needed	61	-	-	-	-	1	63
No hearing aid when needed	62	-	-	-	-	-	63
No glasses when needed	60	-	-	1	-	1	63
Failure to provide other prescribed medical services	55	1	-	2	-	5	62
Failure to fulfill other caretaking obligations	47	-	2	4	1	10	61

TABLE 5.4 SEVERITY OF MANIFESTATIONS OF ABUSE/NEGLECT BY TYPE AT INTAKE (ASSESSMENT 1) AND TIME OF CASE RE-ASSESSMENT (ASSESSMENT 2)

	Physical		Psychological		Material		Neglect	
	Assessment		Assessment		Assessment		Assessment	
	1	2	1	2	1	2	1	2
	#	# %	#	# %	#	# %	#	# %
Worcester - Total	32	17(53.1)	107	65(60.1)	38	24(63.2)	117	65(56.6)
Mild severity	5	8	5	14	1	3	10	22
Moderate severity	17	6	41	22	16	9	49	19
Severe	8	2	54	25	19	10	57	24
? Severity	2	1	7	4	2	2	1	-
"No longer a problem"		16(50.0)		45(42.1)		12(31.6)		44(37.6)
Syracuse - Total	120	38(31.7)	376	172(45.8)	114	52(45.6)	457	205(44.8)
Mild severity	27	21	44	75	15	12	47	45
Moderate severity	61	12	216	44	56	20	213	87
Severe	22	5	101	51	39	17	159	60
? Severity	10	-	15	2	4	3	38	13
"No longer a problem"		92(76.7)		151(40.2)		40(35.1)		176(38.5)
Rhode Island - Total	111	31(27.9)	301	146(48.5)	52	20(38.5)	185	45(24.3)
Mild severity	2	2	4	38	-	3	3	10
Moderate severity	28	12	27	29	10	5	18	8
Severe	72	15	266	78	37	9	157	25
? Severity	9	2	4	1	5	3	7	2
"No longer a problem"		72(64.9)		108(35.9)		31(59.6)		102(55.1)

of improvement than Worcester or Syracuse, but a smaller one for psychological abuse (35.9 percent) and about mid-way between the other two Projects percentages for physical abuse (64.9).

In addition to the number of manifestations as an indicator of degree of severity of maltreatment, the assessment also asked the social workers to rate the level of threat which the behavior of the perpetrators posed for the victim. At all three sites there was a reduction of cases in which the maltreatment was "very" or "moderately" life threatening and an increase in the proportion for which it was "not threatening at all", between the time of intake and close of case (final reassessment). This shift was statistically significant for all three sites ($p<.001$) Table 5.5.

Characteristics of the Victim and Perpetrator

Mental Health of the Victim. To determine whether there was a change in the mental health of the victims during the course of the intervention, several criteria were used. The first was a rating by the case worker of the abused person's orientation to time, place and person and immediate, recent, and remote memory. None of these items had changed significantly from Assessment 1 to Assessment 2 for the three Project cases (Tables 5.6-5.8).

The emotional state of the victim was the second criteria, evaluated both at intake and at the close of case. For the Worcester case load, there was no statistical difference in the emotional state, but both the Syracuse and Rhode Island victims showed an improvement which was significant at the $p<.001$ level. Similarly, the third criterion, a rating of the victim's self esteem did not show a significant increase between intake and reassessment for the Worcester group, but there was a positive change in the Syracuse ($p=.01$) and Rhode Island ($p<.0001$) caseloads (Table 5.9).

Dependency. At the time of the re-assessment, the social workers were requested to indicate any change in the level of dependence of the abused/ neglected elder on the abuser and/or his/her family which had occurred since the initial assessment. Six areas were listed: companionship, daily needs, financial management, financial resources, maintenance of property and transportation. A comparison of these results with those at intake shows a downward shift in the proportion of "very dependent" and an increase in the proportion of "slightly dependent" and "independent". When tested statistically (Wilcoxen), the change in dependence for all five was significant for Syracuse and Rhode Island cases, but only for companionship and daily needs for the Worcester group (Table 5.10). Results were also mixed regarding the change in financial dependency status of the perpetrator on the victim. It was significant for Worcester ($p=.03$) and Syracuse ($p<.001$), but not for the Rhode Island perpetrators (Table 5.11).

Stress. The case workers were also asked to note whether there had been a change in the extent of the stress caused by the abused elder on the abuser: "a lot", "a little", or "not at all". There was no statistical difference in the two ratings for the Worcester cases, but both

TABLE 5.5 RATING OF LEVEL OF THREAT TO HEALTH OF VICTIM AS A CONSEQUENCE OF THE BEHAVIOR OF THE PERPETRATOR AT INTAKE (ASSESSMENT 1) AND CASE RE-ASSESSMENT (ASSESSMENT 2)

	Assessment 1	Assessment 2
	# %	# %
Worcester	n= 59	n= 57
Life threatening	4(7.0)	1(2.0)
Very threatening	24(42.1)	5(10.0)
Moderately threatening	26(45.6)	14(28.0)
Not threatening at all	3(5.3)	28(56.0)
Not appropriate-perpetrator absent	-	2(4.0)
Unknown	2	7
Syracuse	n=135	n=127
Life threatening	9(6.8)	2(1.9)
Very threatening	38(28.6)	6(5.6)
Moderately threatening	61(45.9)	15(13.9)
Not threatening at all	25(18.8)	84(77.8)
Not appropriate-perpetrator absent	-	1(0.9)
Unknown	2	19
Rhode Island	n=134	n=125
Life threatening	52(41.3)	9(9.4)
Very threatening	38(30.7)	8(8.3)
Moderately threatening	34(27.0)	15(15.6)
Not threatening at all	2(1.6)	60(62.5)
Not appropriate-perpetrator absent	-	4(4.2)
Unknown	8	29

Level of significance (Wilcoxon Matched-Pairs Signed-Ranks Test) $p<.001$ for the three samples

TABLE 5.6 RATING OF MENTAL STATUS OF ABUSED/NEGLECTED ELDER AT INTAKE (ASSESSMENT 1) AND AT TIME OF CASE RE-ASSESSMENT (ASSESSMENT 2) - WORCESTER

		Assessment 1	Assessment 2
		# %	# %
Orientation Problem			
Person:	Yes	6(11.1)	7(15.2)
	Sometimes	13(24.1)	12(26.1)
	No	25(64.8)	27(58.7)
	Unknown	5	11
Place	Yes	6(11.3)	7(15.6)
	Sometimes	8(15.1)	9(20.0)
	No	39(73.6)	29(64.4)
	Unknown	6	12
Time:	Yes	8(15.1)	8(18.6)
	Sometimes	10(18.9)	11(25.6)
	No	35(66.0)	24(55.8)
	Unknown	6	14
Memory Problem			
Immediate:	Yes	8(16.7)	9(23.1)
	Sometimes	6(12.5)	5(12.8)
	No	34(70.8)	25(64.1)
	Unknown	11	18
Recent:	Yes	8(17.8)	9(23.1)
	Sometimes	10(22.2)	8(20.5)
	No	27(60.0)	22(56.4)
	Unknown	14	18
Remote:	Yes	5(13.5)	6(17.1)
	Sometimes	7(18.9)	5(14.3)
	No	25(67.6)	24(68.6)
	Unknown	22	22

No significant difference between Assessment 1 and 2 (Wilcoxon Matched-Pairs Signed-Ranks Test)

TABLE 5.7 RATING OF MENTAL STATUS OF ABUSED/NEGLECTED ELDER AT INTAKE (ASSESSMENT 1) AND AT TIME OF CASE RE-ASSESSMENT (ASSESSMENT 2) - SYRACUSE

		Assessment 1	Assessment 2
		# %	# %
Orientation Problem			
Person:	Yes	17(13.3)	17(16.7)
	Sometimes	59(46.1)	44(43.1)
	No	52(40.6)	41(40.2)
	Unknown	7	25
Place:	Yes	20(15.5)	26(25.2)
	Sometimes	47(36.4)	26(25.2)
	No	62(48.1)	51(49.5)
	Unknown	6	24
Time:	Yes	21(16.3)	25(24.5)
	Sometimes	60(46.5)	33(32.4)
	No	48(37.2)	44(43.1)
	Unknown	8	25
Memory Problem			
Immediate:	Yes	27(21.3)	23(22.8)
	Sometimes	52(40.9)	40(39.6)
	No	48(35.9)	38(37.6)
	Unknown	7	26
Recent:	Yes	26(20.3)	25(24.8)
	Sometimes	56(43.8)	36(35.6)
	No	46(35.9)	40(39.6)
	Unknown	7	26
Remote:	Yes	22(17.6)	22(22.0)
	Sometimes	49(39.2)	33(33.0)
	No	54(43.2)	45(45.0)
	Unknown	10	27

No significant difference between Assessment 1 and 2 (Wilcoxon Matched-Pairs Signed-Ranks Test)

TABLE 5.8 RATING OF MENTAL STATUS OF ABUSED/NEGLECTED ELDER AT INTAKE (ASSESSMENT 1) AND AT TIME OF CASE RE-ASSESSMENT (ASSESSMENT 2) - RHODE ISLAND

		Assessment 1	Assessment 2
		# %	# %
Orientation Problem			
Person:	Yes	10(10.9)	6(8.6)
	Sometimes	12(13.1)	6(8.6)
	No	70(76.1)	58(82.9)
	Unknown	42	55
Place:	Yes	12(12.9)	7(9.9)
	Sometimes	13(14.0)	8(11.3)
	No	68(73.1)	56(78.9)
	Unknown	41	54
Time:	Yes	12(13.2)	7(10.1)
	Sometimes	13(14.3)	8(11.6)
	No	66(72.5)	54(78.3)
	Unknown	43	56
Memory Problem			
Immediate:	Yes	14(15.4)	7(10.0)
	Sometimes	11(12.1)	8(11.4)
	No	66(72.5)	55(78.6)
	Unknown	43	55
Recent:	Yes	14(15.6)	8(11.6)
	Sometimes	13(14.4)	9(13.0)
	No	63(70.0)	52(75.4)
	Unknown	44	56
Remote:	Yes	13(14.8)	9(13.0)
	Sometimes	12(13.6)	8(11.6)
	No	63(71.6)	52(75.4)
	Unknown	46	56

No significant difference between Assessment 1 and 2 (Wilcoxon Matched-Pairs Signed-Ranks Test)

TABLE 5.9 RATING OF EMOTIONAL STATUS OF ABUSED/NEGLECTED ELDER AT INTAKE (ASSESSMENT 1) AND AT TIME OF CASE RE-ASSESSMENT (ASSESSMENT 2)

		Assessment 1	Assessment 2
		# %	# %
Worcester		n= 59	n= 57
Emotional State:	Excellent	-	3(6.7)
	Good	21(41.2)	22(48.9)
	Poor	30(58.8)	20(44.4)
	Unknown	8	12
Self-Esteem:	Very high	-	1(3.6)
	Moderately high	20(55.6)	16(57.1)
	Moderately low	14(38.9)	11(39.3)
	Very low	2(5.6)	-
	Unknown	23	19
Syracuse		n=135	n=125
***Emotional State:	Excellent	2(1.6)	4(4.1)
	Good	32(25.8)	62(63.3)
	Poor	90(72.6)	32(32.7)
	Unknown	11	29
*Self-Esteem	Very high	3(2.7)	3(3.2)
	Moderately high	17(15.2)	37(39.4)
	Moderately low	68(60.7)	33(35.1)
	Very low	24(21.4)	21(22.3)
	Unknown	23	33
Rhode Island		n=134	n=125
***Emotional State:	Excellent	1(1.0)	7(9.3)
	Good	27(27.3)	48(64.0)
	Poor	71(71.7)	20(26.6)
	Unknown	35	50
**Self-Esteem:	Very high	7(8.1)	10(16.4)
	Moderately high	23(26.4)	33(54.1)
	Moderately low	33(37.9)	11(18.0)
	Very low	24(27.6)	7(11.5)
	Unknown	47	64

Level of significance (Wilcoxon Matched-Pairs Signed-Ranks Test)
*p<.05; **p<.01; ***p<.001

TABLE 5.10 EXTENT OF DEPENDENCE OF THE ABUSED/NEGLECTED ELDER ON THE ABUSER OR FAMILY AT TIME OF CASE RE-ASSESSMENT

	Independent	Slightly Dependent	Very Dependent	N/A
	# %	# %	# %	#
Worcester (n=57)				
*Companionship	16(29.6)	13(24.1)	25(46.3)	3
**Daily needs	28(51.9)	8(14.8)	18(33.3)	3
Financial management	23(42.6)	4(7.4)	27(50.0)	3
Financial resources	29(58.0)	14(28.0)	7(14.0)	7
Maintenance of property	23(45.1)	9(16.7)	19(35.2)	6
Transportation	24(49.0)	4(8.2)	21(42.9)	8
Other	3	-	8	46
Syracuse (n=127)				
***Companionship	12(15.6)	17(22.1)	48(62.3)	50
**Daily needs	18(24.0)	21(28.0)	36(48.0)	52
*Financial management	18(22.8)	18(22.8)	43(54.4)	48
**Financial resources	51(60.7)	14(16.7)	9(10.7)	53
*Maintenance of property	15(21.4)	11(15.7)	44(62.9)	57
*Transportation	26(37.1)	7(10.0)	37(52.9)	57
Other	-	1	6	120
Rhode Island (n=125)				
***Companionship	50(50.5)	18(18.2)	31(31.3)	26
***Daily needs	68(69.4)	9(9.2)	21(21.4)	27
**Financial management	70(89.8)	6(7.7)	2(2.6)	27
*Financial resources	90(91.8)	3(3.1)	5(5.1)	27
**Maintenance of property	48(56.5)	7(8.2)	30(35.3)	40
***Transportation	62(68.1)	8(8.8)	21(23.1)	34
Other	10	1	3	111

Level of significance (Wilcoxon Matched-Pairs Signed-Ranks Test) comparing Assessment and Re-Assessment data *$p<.05$; **$p<.01$; ***$p<.001$

TABLE 5.11 EXTENT OF DEPENDENCE OF THE ABUSER ON THE ABUSED/NEGLECTED ELDER FOR FINANCIAL RESOURCES AT INTAKE (ASSESSMENT 1) AND AT TIME OF CASE RE-ASSESSMENT (ASSESSMENT 2)

	Assessment 1	Assessment 2
	# %	# %
*Worcester		
Independent	11(25.6)	15(40.5)
Slightly dependent	14(32.6)	13(35.1)
Very dependent	18(41.9)	9(24.3)
No answer	16	20
***Syracuse		
Independent	51(40.8)	56(60.9)
Slightly dependent	28(22.4)	19(36.5)
Very dependent	46(36.8)	17(18.5)
No answer	10	35
Rhode Island		
Independent	17(22.1)	22(40.7)
Slightly dependent	18(23.4)	8(14.8)
Very dependent	42(54.5)	24(44.4)
No answer	57	71

Level of significance (Wilcoxon Matched-Pairs Signed-Ranks Test)
*p $<$.05; ***p $<$.001

the Syracuse cases and the Rhode Island did show a significant reduction ($p<.001$ and $p=.001$, respectively) (Table 5.12). Another question which appeared on the intake and re-assessment form concerned the quality of the relationship of the abused and abuser. There was a significant improvement for all the Model Projects with a drop in the percentage of "poor" responses for the Worcester cases from three quarters to one-half from three-quarters to two-fifths ($p=.048$), for the Syracuse group ($p<.001$); and from three-quarters to one-third for Rhode Island, ($p<.001$) (Table 5.13).

When a comparison was made between the severity of the problems experienced by the perpetrators at intake and later at reassessment Table 5.14), the Worcester and Rhode Island cases showed no significant change. The Syracuse data, on the other hand, indicated that there has been a significant reduction in the severity of alcohol abuse ($p=.04$), past suicide attempts, recent medical problems ($p=.015$), recent and long term financial problems ($p=.003$), history of mental illness ($p=.002$) and lack of needed services ($p=.002$).

Intervention Barriers

The Re-assessment forms also included a question about the change in the barriers to service delivery which had been noted at the time of intake (see Table 5.15). From the reports, it appears that for the Worcester cases there was a significant reduction in the degree of hindrance caused by the "receptivity (or lack thereof) of the perpetrator to receive help" while for Syracuse cases there was a significant decrease in all the hindrance of barriers except the two which initially involved ten percent or less of the cases (number of agencies and lack of protective services). The Rhode Island case data show that there had been a significant reduction in the degree to which "receptivity of the abused and abuser", "availability of approrpiate services", "legal implications", and "lack of respite and protective services" had hampered the delivery of services.

C. Discussion

The preceding portion of the evaluation was designed to determine whether there has been a change in the abuse/neglect situation during the time of the Model Project intervention. Several aspects were investigated: the manifestations and severity of the abuse and neglect acts; the dependency status of the abused and abuser; the presence of stress on the abuser; and barriers to service delivery.

Although the changes in severity of the maltreatment were not tested statistically, there was considerable improvement in the number and degree of severity of the manifestations found in the Worcester Project case load during the course of the intervention and a drop in the level of threat which the actions of the perpetrator posed to the health of the victim. There appeared to be some success in reducing the dependency of the abused on the abuser regarding companionship and daily needs, probably through the employment of homemakers, but not for financial management, transportation and maintenance of property. The mental

TABLE 5.12 THE EXTENT TO WHICH THE ABUSED/NEGLECTED ELDER IS A SOURCE OF STRESS TO ABUSER AND/OR FAMILY AT INTAKE (ASSESSMENT 1) AND AT TIME OF CASE RE-ASSESSMENT (ASSESSMENT 2)

	Assessment 1	Assessment 2
	# %	# %
Worcester		
A lot	24(66.7)	17(37.8)
A little	5(13.9)	13(28.9)
Not at all	7(19.4)	14(31.1)
No answer	23	13
***Syracuse		
A lot	74(56.5)	28(25.7)
A little	42(32.1)	44(40.4)
Not at all	15(11.5)	37(33.9)
No answer	4	26
**Rhode Island		
A lot	49(55.7)	20(26.3)
A little	18(20.5)	20(26.3)
Not at all	21(23.9)	36(47.4)
No answer	46	49

Level of significance (Wilcoxon Matched-Pairs Signed-Ranks Test)
**$p < .01$; ***$p < .001$

TABLE 5.13 THE QUALITY OF THE RELATIONSHIP BETWEEN THE ABUSED/NEGLECTED ELDER AND THE ABUSER AT INTAKE (ASSESSMENT 1) AND AT TIME OF CASE RE-ASSESSMENT (ASSESSMENT 2)

	Assessment 1 # %	Assessment 2 # %
*Worcester		
Poor	44(77.2)	32(60.4)
Good	12(21.1)	18(34.0)
Excellent	1(1.8)	3(5.7)
No Answer	2	4
***Syracuse		
Poor	93(71.0)	39(38.6)
Good	37(28.2)	55(54.5)
Excellent	1(0.8)	7(6.9)
No Answer	4	25
***Rhode Island		
Poor	83(79.0)	24(33.8)
Good	19(18.1)	43(60.6)
Excellent	3(2.9)	4(5.6)
No Answer	29	54

Level of significance (Wilcoxon Matched-Pairs Signed-Ranks Test)
*p$<$.05; **p$<$.01: ***p$<$.001

TABLE 5,14 SEVERITY OF PERPETRATORS' PROBLEMS   CASE RE-ASSESSMENT

	None	Mild	Moderate	Severe	?	No longer a problem	N/A
	#	#	#	#	#	#	#
Worcester (n=57)							
Alcohol abuse	34	3	6	5	1	3	5
Drug abuse	49	-	-	1	1	1	5
History of mental illness	33	1	7	9	-	1	6
Lack of needed services	43	-	5	5	-	1	3
Long-term financial problem	45	-	3	5	-	-	4
Long-term medical problem	38	2	8	3	1	-	5
Past suicide attempt	50	-	1	2	-	-	4
Recent birth of child	52	-	1	-	-	-	4
Recent financial problem	44	2	3	3	-	1	4
Recent divorce/separation	47	-	1	2	1	1	5
Recent death of spouse/ significant other	38	4	7	5	-	-	3
Recent medical complaint	48	-	1	1	1	1	5
Other	35	2	7	4	2	1	6
Syracuse (n=127)							
Alcohol abuse	57	14	13	9	-	5	29
Drug abuse	81	5	10	1	-	2	28
History of mental illness	61	7	19	6	1	5	28
Lack of needed services	44	5	15	14	1	17	31
Long-term financial problem	63	7	13	9	-	6	29
Long-term medical problem	60	9	18	11	-	1	28
Past suicide attempt	95	-	2	1	-	2	28
Recent birth of child	98	1	-	-	-	-	28
Recent financial problem	56	10	10	11	1	10	29
Recent divorce/separation	83	4	3	5	1	4	28
Recent death of spouse/ significant other	84	5	3	1	-	5	29
Recent medical complaint	56	12	14	4	2	10	29
Other	69	7	10	8	3	-	30
Rhode Island (n=125)							
Alcohol abuse	40	4	6	16	-	3	56
Drug abuse	61	1	1	6	-	-	56
History of mental illness	44	1	5	16	1	1	57
Lack of needed services	60	1	2	4	-	3	55
Long-term financial problem	42	3	4	20	-	1	55
Long-term medical problem	59	1	-	8	-	-	57
Past suicide attempt	65	-	-	4	-	-	56
Recent birth of child	67	-	-	2	-	-	56
Recent financial problem	63	-	1	5	-	1	55
Recent divorce/separation	61	-	-	5	2	1	56
Recent death of spouse/ significant other	64	-	1	4	-	-	56
Recent medical complaint	63	-	2	4	-	-	57
Other	61	1	-	5	2	-	56

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TABLE 5.15 DEGREE OF HINDRANCE OF BARRIERS TO DELIVERY OF APPROPRIATE SERVICES - CASE REASSESSMENT

	None	A Little	A Lot	no longer a problem	N/A
	# %	# %	# %	# %	#
Worcester (n=57)					
Availability of services	19(57.6)	4(12.1)	7(21.2)	3(9.1)	24
Bureaucratic red-tape	18(72.0)	2(8.0)	3(12.0)	2(8.0)	32
Coordination of agencies	34(87.2)	1(2.6)	1(2.6)	3(7.7)	18
Coordination of services	31(83.8)	3(8.1)	2(5.4)	1(2.7)	20
Lack of protective services	15(83.3)	-	2(16.7)	-	39
Lack of respite care	10(58.8)	3(17.6)	2(11.8)	2(11.8)	40
Lack support groups-caretakers	10(62.5)	4(25.0)	1(6.3)	1(6.3)	41
Legal implications-intervention	14(51.9)	6(22.2)	4(14.8)	3(11.1)	30
Non-reimbursement for services	18(85.7)	1(4.8)	2(9.5)	-	36
Number of agencies involved	31(88.6)	-	2(5.7)	2(5.7)	22
Receptivity of abused to help	17(32.7)	14(26.9)	14(26.9)	7(13.5)	5
**Receptivity of abuser to help	8(16.7)	11(22.9)	20(41.7)	9(18.8)	9
Other	2(18.2)	2(18.2)	6(54.5)	1(9.1)	46
Syracuse (n=127)					
***Availability of services	26(27.7)	24(24.5)	6(6.4)	39(41.5)	33
*Bureaucratic red tape	20(52.6)	6(15.8)	4(10.5)	8(21.1)	89
***Coordination of agencies	51(61.4)	8(9.6)	-	24(28.9)	44
***Coordination of services	48(57.8)	6(7.2)	1(1.2)	28(33.7)	44
Lack of protective services	59(89.4)	2(3.0)	1(1.5)	4(6.1)	61
**Lack of respite care	41(62.1)	4(6.1)	4(6.1)	17(25.8)	61
***Lack support groups-caretakers	27(40.3)	18(26.9)	2(3.0)	20(29.9)	60
**Legal implications-intervention	42(51.9)	12(14.8)	8(9.9)	19(23.5)	46
***Non-reimbursement for services	34(40.0)	10(11.8)	19(22.4)	22(25.9)	42
Number of agencies involved	73(93.6)	2(2.6)	-	3(3.8)	49
***Receptivity of abused to help	30(28.3)	21(19.8)	10(9.4)	45(42.5)	21
***Receptivity of abuser to help	11(10.7)	22(21.4)	15(15.5)	54(52.4)	24
Other	9(56.3)	2(12.5)	3(18.8)	2(12.5)	110
Rhode Island (n=125)					
*Availability of services	54(77.1)	8(11.4)	3(4.3)	5(7.1)	55
Bureaucratic red tape	12(75.0)	2(12.5)	-	2(12.5)	109
Coordination of agencies	74(96.1)	2(2.6)	-	1(1.3)	48
Coordination of services	76(97.4)	2(2.6)	-	-	47
**Lack of protective services	12(31.6)	2(5.3)	16(42.1)	8(21.1)	87
*Lack of respite care	16(51.6)	6(19.4)	3(9.7)	6(19.4)	94
Lack support groups-caretakers	20(62.5)	5(15.6)	2(6.3)	5(15.6)	93
**Legal implications-intervention	24(53.3)	6(13.3)	5(11.1)	10(22.2)	80
Non-reimbursement for services	17(100)	-	-	-	108
Number of agencies involved	76(100)	-	-	-	49
***Receptivity of abused to help	24(26.1)	15(16.3)	21(22.8)	32(34.8)	33
***Receptivity of abuser to help	13(13.8)	7(7.4)	42(44.7)	32(34.0)	31
Other	3(75.0)	-	-	1(25.0)	121

Level of significance (Wilcoxon Matched-Pairs Signed-Ranks Test) comparing Assessment and Re-Assessment data *$p < .05$; **$p < .01$; ***$p < .001$ (See Table 3.29 for Assessment data).

health of the victim (including cognitive and emotional status and self-esteem) did not change nor was there any change in the degree of stress which the victim caused the perpetrator and/or family. Although the quality of the relationship between the victim and perpetrator did improve, there was no change in the perpetrator's problems. However, there was a reduction in the financial dependency of the perpetrator on the victim. Of all the barriers to service delivery considered by the Worcester staff, only "receptivity of the abuser to help" improved significantly.

The findings from both the Syracuse and Rhode Island assessments and re-assessments indicate a significant change in several areas: manifestations of abuse and neglect, level of threat, and reduced dependency of the victim in all areas under investigation. Although the cognitive status of the victims did not change over the course of the intervention, there was an improvement in the emotional state and level of self esteem. Stress from the victim on the perpetrator was reduced and the quality of the relationship between the two improved. The Syracuse staff also noted a positive change in the severity of the problems facing the perpetrator and a reduction in his/her dependency on the victim for financial resources; the Rhode Island staff did not find these gains. Both groups indicate improvement in the barriers to effective service delivery, although the Syracuse staff recorded reductions in several more areas than the Rhode Island Project.

In reviewing these variables, it appears that the Worcester Project at least in its own eyes, was less successful in changing the abuse situation than either Syracuse or Rhode Island. While all three noted a reduction in the manifestations of the abuse or neglect situations, and in the dependency of the victim on the perpetrator and vice versa, the Worcester case workers recorded no change in the level of stress caused by the victim or improvement in his/her emotional state or reduction in the problems facing the perpetrator, areas in which the Syracuse and Rhode Island case workers note positive changes, along with less hindrance from the barriers to service delivery. Before speculating as to why this difference exists, it might be useful to look further at the success of the Projects in resolving the cases, and the factors which contributed to it.

II. Case Resolution

A. Methodology

The first part of this section provides the descriptive data on case resolution and reports on the contribution which seven factors listed on the Case Re-assessment form made to the resolution of the cases by site. In the second part, variables describing characteristics of the victim, perpetrator, situation, and intervention strategies are examined to determine their relationship to successful case resolution (See Figure 3). For this part of the analyses, the responses to the question on case resolution were reduced from four categories ("not at all", "a little", "a lot", "completely") to two: unresolved ("not at

FIGURE 3 Variables in Case Resolution Analysis

1. Victim Characteristics

- Age
- Marital Status
- Sex
- Income
- Use of Supportive Devices for Mobility
- Number of Medications
- Problem with Orientation to Person, Place and Time
- Problem with Immediate, Recent, or Remote Memory
- Emotional State
- Number of Social Contacts
- Self-Esteem Rating
- Source of Stress to Perpetrator
- Dependency on Perpetrator in the Following Areas:

  - Companionship
  - Daily Needs
  - Financial Management
  - Financial Resources
  - Maintenance of Property
  - Transportation

- Difficulty With Instrumental Activities of Daily Living:

  - Personal Care
  - Mobility/Communication
  - Mealtime Activities
  - Safety/Security of Property
  - Management of Personal Affairs
  - General Shopping
  - Transportation
  - Household Management

2. Perpetrator Characteristics

- Age
- Sex
- History of Alcohol Abuse
- Availability of Family Member for Support
- Availability of Someone to Call in Crisis
- Unrealistic Expectations of Abused
- Financial Dependency on Abused

FIGURE 3 Variables in Case Resolution Analysis (cont.)

3. Situational Characteristics

   - Household Composition
   - Primary Type of Abuse/Neglect
   - Relationship of Perpetrator to Victim
   - Perpetrator Lives/Does Not Live with Victim
   - Quality of the Relationship between Perpetrator and Victim
   - Household Income
   - Levels of Threat

4. Intervention Barriers and Strategy

   Barriers to Intervention:

   - Number of Agencies
   - Coordination of Services
   - Coordination of Agencies
   - Receptivity of Abused
   - Receptivity of Abuser
   - Availability of Services
   - Legal Implications
   - Lack of Respite Care
   - Lack of Support Group
   - Lack of Protective Services
   - Non Reimbursement for Services
   - Bureaucratic Red-Tape

all" and "a little") and resolved ("a lot" and "completely"). Also, the data from the three Projects were pooled since the objective was to identify the characteristics which might contribute to successful case resolution rather than to look for differences in outcome among the sites. To test the soundness of this decision, the cases from the three Projects were tested for differences on a set of socio-demographic and health-function variables. The results of the analyses are given below in sub-sections marked Model Project Case Load Comparison; Case Resolution and Disposition; and Factors Contributing to Case Resolution. The chi-square test was used to detect differences at a significance level of $p \leq .05$.

B. Results

Model Project Case Load Comparisons

Prior to pooling the three Project samples for the case resolution analysis, they were compared for significant differences on selected socio-demographic and health-function variables. Those factors which depended on the subjective judgment of the workers (e.g., ratings concerning amount of stress, dependence, mental health status, etc.) were purposely excluded. There were no differences among the three groups of victims regarding age, sex, marital status, and living arrangements nor in their use of supportive devices for mobility or weight change (the latter used as proxies for functional health) (Table 5.16). The perpetrators were also alike in terms of sex and living arrangements history of mental illness and alcoholism, but did differ in age, with the Rhode Island group having a significantly larger percentage (51.3) of abusers under 50 years of age compared to Worcester (39.0) and Syracuse (35.7) (p=.0386) (Table 5.17). . Given the degree of similarity among the victims perpetrator groups, the samples were combined for the study of the factors related to case resolution (Table 5.22).

Case Resolution and Disposition

One of the last questions on the case reassessment form asked the case worker to note the extent to which the case had been resolved: "completely", "a lot", "a little" or "not at all". About one third of the Worcester (37.3 percent) and Syracuse (32.1 percent) cases were resolved, and a somewhat larger proportion (41.5 percent) of the Rhode Island Group. Little or "no" success was found in about one-third of the Worcester (34.3 percent) and about one quarter of the Syracuse (22.9 percent) and Rhode Island (26.4) cases. Regarding the status of the case at time of re-assessment, there were a number of alternatives mentioned (Table 5.18). Almost one out of eight of the Syracuse victims had died, about half that proportion (6.5 percent) of the Rhode Island victims and none of the Worcester group. Approximately one-quarter (23.0 percent) of the Syracuse victims were admitted to nursing or rest homes, almost twice as large a proportion as Worcester (12.3 percent) and Rhode Island (13.0 percent). Less than one-tenth of the sample from each site were hospitalized (Worcester, 8.8 percent; Syracuse 5.6, percent; and Rhode Island 3.3 percent).

TABLE 5.16 A COMPARISON OF THE VICTIMS OF ELDER ABUSE/NEGLECT BY SITE - SOCIODEMOGRAPHIC AND HEALTH FACTORS

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Age	n.s.		
59-64 years	11(18.6)	15(11.2)	27(20.3)
65-74 years	13(22.0)	35(26.1)	40(30.1)
75-84 years	25(42.4)	47(35.1)	46(34.6)
85 and older	10(16.9)	37(27.6)	20(15.0)
No answer	-	1	1
b) Sex	n.s.		
Male	12(20.3)	21(15.6)	27(20.1)
Female	47(79.7)	114(84.4)	107(79.9)
c) Marital Status	n.s.		
Single	7(12.1)	8(6.0)	10(8.0)
Married	21(36.2)	41(30.8)	38(30.4)
Widowed	26(44.8)	72(54.1)	61(48.8)
Divorced/Separated	4(6.9)	12(9.0)	16(12.8)
No answer	1	2	9
d) Living Arrangements	n.s.		
Lives alone	9(13.6)	37(27.6)	31(23.3)
Lives with others	51(86.4)	97(72.4)	106(76.7)
No answer	-	1	1
e) Victim requires supportive devices/bedridden	n.s.		
Yes	27(51.9)	78(59.5)	46(46.5)
No	25(48.1)	53(40.5)	53(53.5)
No answer	7	4	36
f) Victim has had recent weight change	n.s.		
Yes	5(14.7)	4(7.0)	3(8.3)
No	29(85.3)	53(93.0)	33(91.7)
No answer	25	78	98

n.s. = no significant difference in chi-square analyses.

TABLE 5.17 A COMPARISON OF THE PERPETRATORS OF ELDER ABUSE/NEGLECT BY SITE

	Worcester n=59	Syracuse n=135	Rhode Island n=134
	# %	# %	# %
a) Age	p=.0386		
Under 50 years	23(39.0)	46(35.7)	61(51.3)
50 years and over	36(61.0)	83(64.3)	58(48.7)
No answer	-	6	15
b) Sex	n.s.		
Male	42(71.2)	78(58.6)	84(66.1)
Female	17(28.8)	55(41.4)	43(33.9)
No answer	-	2	7
c) Perpetrator lives with victim	n.s.		
Yes	49(83.1)	91(67.9)	100(76.9)
No	10(16.9)	43(32.1)	30(23.1)
No answer	-	1	4
d) History of mental illness	n.s.		
Yes	24(40.7)	48(38.7)	43(36.4)
No	35(59.3)	76(61.3)	75(63.6)
No Answer	-	11	16
e) History of alcohol abuse	n.s.		
Yes	21(35.6)	49(39.5)	52(44.1)
No	38(64.4)	75(60.5)	66(55.9)
No answer	-	11	16

n.s. = no significant difference in chi-square analysis

TABLE 5.18 EXTENT TO WHICH CASES OF ELDER ABUSE/NEGLECT WERE RESOLVED BY SITE*

	Worcester n=57	Syracuse n=127	Rhode Island n=125
	# %	# %	# %
Not at all	7(13.7)	5(4.6)	18(17.0)
A little	11(21.6)	20(18.3)	10(9.4)
A lot	14(27.5)	49(45.0)	34(32.1)
Completely	19(37.3)	35(32.1)	44(41.5)
No Answer			

*p= .0089

TABLE 5.19 STATUS OF VICTIM AND PERPETRATOR AT CASE RE-ASSESSMENT BY SITE*

	Worcester n=57	Syracuse n=127	Rhode Island n=125
	# %	# %	# %
Victim died		15(11.9)	8(6.5)
Victim in nursing home/rest home	7(12.3)	29(23.0)	16(13.0)
Victim in hospital	5(8.8)	7(5.6)	4(3.3)
Victim in new housing arrangement	5(8.8)	9(7.1)	13(10.6)
Perpetrator died/absent	6(10.5)	11(8.7)	17(13.8)
Perpetrator in nursing home	1(1.8)	1(0.8)	3(2.4)
Housing arrangement unchanged	33(57.9)	72(56.7)	62(50.4)
No answer	-	-	2

*total is greater than 100 percent because of multiple responses

New housing situations were arranged for 8.8 percent of the Worcester victims; 7.1 percent, Syracuse; and 10.6, Rhode Island. At the time of case re-assessment, 10.5 percent of the perpetrators had died or had been placed in a nursing home (1.8 percent). In the Syracuse case load, 8.7 percent of the perpetrators had died or left the scene and 0.8 percent had been placed in a nursing home. The Rhode Island assessment forms indicate that 13.8 percent of the perpetrators had died or were absent and 3.4 percent were in nursing homes. Thus, at the end of the two year study period, almost one-half of the victims were still in the same housing situation that they had when the case was first opened (Worcester, 57.9 percent; Syracuse, 56.7 percent; and Rhode Island, 50.4 percent) (Table 5.19).

To provide further information concerning case resolution, the social workers were asked to note the extent to which various interventions had contributed to the resolution of the case. The numbers and percent of cases in each category (very negative, somewhat negative, no effect, somewhat positive, and very positive) are given in Tables 5.20-5.22). Because of the small number of Worcester cases for which responses were given, the percentages have not been included. So that these statistics could be compared by the reader across the three sites, a rating scale was developed ranging from -2 (very negative) to +2 (very positive). According to Table 5.23, which presents the group means for the eight intervention strategies, the most effective for the Worcester program in order were: "changes in the social/living situation of the abused/neglected" (1.8), "changes in the circumstances of the abused/neglected which precipitated abuse/neglect" (1.6), "removal of barriers" (1.5), and "specific interventions" (1.5), followed by "changes in the unhealthy interdependencies between abused/ neglected and abuser" (1.4), "reduction in stress caused by abused/ neglected" (1.3), and least successful as a strategy "reduction in problems in life of abuser" (1.0) and "changes in circumstances of abuser which precipitated abuse/neglect" (1.0). The above order of interventions matches closely the response by the Syracuse case workers except for "changes in the circumstances of the abuser", which contrary to the report of Worcester staff, was found to be one of the least effective interventions (0.7). The order of ratings for the Rhode Island case load was also very similar, although "specific interventions" was most effective for this project. Again, "changes in the circumstances of the abuser which precipitated the abuse/neglect" was the least effective strategy.

When the five categories (of responses to this question) were reduced to three (very and somewhat negative, no effect, somewhat and very positive) and subjected to a chi-square analyses to compare the results of the three Projects, four of the eight strategies were significantly different: "changes in the social/living situation of abused/neglect" (p=.0183); "reduction in stress" (p=.0433), "changes in circumstances of the abuser" (p=.004) and "changes in circumstances of the abused" (p=.0004). In each of these instances, the Worcester case workers assessed these strategies more positively than the Syracuse and Rhode Island counterparts. (Table 5.23)

TABLE 5.20 DEGREE TO WHICH EVENTS AFFECTED RESOLUTION OF THE CASE - WORCESTER

	very negative	somewhat negative	no effect	somewhat positive	very positive	N/A
	#	#	#	#	#	#
Changes in social/living situation of abused/ neglected	1	-	-	2	17	37
Removal of barriers to intervention	-	-	-	8	9	40
Specific intervention strategies	-	-	2	2	8	45
Changes in unhealthy interdependencies between abused/neglected and abuser	-	-	-	4	3	50
Reduction in stress caused by abused/neglected	-	-	2	8	6	41
Reduction in problems in life of abuser	-	-	3	7	3	44
Changes in circumstances of abuser which precipitated abuse/neglect	-	-	2	1	2	52
changes in circumstances of abused/neglected which precipitated abuse/neglect	-	-	1	4	11	51

TABLE 5.21 DEGREE TO WHICH EVENTS AFFECTED RESOLUTION OF THE CASE - SYRACUSE

	very negative	somewhat negative	no effect	somewhat positive	very positive	N/A
	# %	# %	# %	# %	# %	#
Changes in social/living situation of abused/ neglected	– –	2(2.7)	9(12.0)	14(18.7)	50(66.7)	52
Removal of barriers to intervention	– –	– –	11(10.9)	37(36.6)	53(52.5)	26
Specific intervention strategies	1(0.9)	6(5.6)	15(13.9)	43(39.8)	43(39.8)	19
Changes in unhealthy interdependencies between abused/neglected and abuser	1(1.1)	2(2.1)	24(25.5)	24(25.5)	43(45.8)	33
Reduction in stress caused by abused/neglected	– –	1(1.2)	17(20.7)	27(32.9)	37(45.1)	45
Reduction in problems in life of abuser	–	4(4.8)	26(31.0)	31(36.9)	23(27.4)	43
Changes in circumstances of abuser which precipitated abuse/neglect	4(4.7)	9(10.6)	18(21.2)	32(37.7)	22(25.9)	42
changes in circumstances of abused/neglected which precipitated abuse/neglect	6(6.7)	6(6.7)	16(17.8)	35(38.9)	27(30.0)	37

TABLE 5.22 DEGREE TO WHICH EVENTS AFFECTED RESOLUTION OF THE CASE - RHODE ISLAND

	very negative	somewhat negative	no effect	somewhat positive	very positive	N/A
	# %	# %	# %	# %	# %	#
Changes in social/living situation of abused/ neglected	- -	- -	22(27.7)	22(23.4)	46(48.9)	35
Removal of barriers to intervention	- -	1(1.3)	15(18.8)	29(36.3)	35(43.8)	45
Specific intervention strategies	- -	- -	16(17.4)	26(28.3)	50(54.4)	33
Changes in unhealthy interdependencies between abused/neglected and abuser	- -	- -	25(29.8)	24(28.6)	35(41.7)	41
Reduction in stress caused by abused/neglected	- -	1(1.6)	26(41.3)	15(23.8)	21(33.3)	62
Reduction in problems in life of abuser	1(1.7)	- -	30(52.6)	15(25.9)	12(20.7)	67
Changes in circumstances of abuser which precipitated abuse/neglect	1(1.7)	1(1.7)	30(52.6)	16(28.1)	9(15.8)	68
Changes in circumstances of abused/neglected which precipitated abuse/neglect	- -	1(1.4)	28(40.0)	19(27.2)	22(31.4)	55

TABLE 5.23 EFFECTIVENESS OF INTERVENTIONS ON RESOLUTION OF THE ELDER ABUSE/NEGLECT CASES[1]

	Worcester n=57	Syracuse n=127	Rhode Island n=125
*Changes in social/living situation of abused/neglected	1.8	1.5	1.3
Removal of barriers	1.5	1.4	1.2
Specific interventions	1.5	1.1	1.4
Changes in unhealth interdependencies between abused and abuser	1.4	1.1	1.1
*Reduction in stress caused by abuse	1.3	1.2	0.8
Reduction in life problems of the abuser	1.0	0.9	0.6
**Changes in the circumstances of the abuser which precipitated the abuse	1.0	0.7	0.5
***Changes in the circumstances of the abused which precipitated the abuse	1.6	0.8	0.7

[1] Rating scale: -2=very negative; -1=somewhat negative; 0=no effect +1=somewhat positive; and +2=very positive
Chi-Square level of significance based on proportion of cases in three categories (very and somewhat negative, no effect, and somewhat and very positive): $*p<.05$; $**p<.01$; $***p<.001$

Factors Contributing to Case Resolution

The factors which appeared to have some potential bearing on case resolution were identified and divided into four categories as shown in Figure 3. The chi-square test was used to determine significant differences of the $p=.05$ level.

Victim Characteristics. There was no relationship between case resolution and victim variables such as age, marital status, sex, income, sue of supportive devices, number of medications, memory, number of social contacts, self esteem, and source of stress. Significant differences were found for temporal orientation, dependency needs related to financial resources, transportation and problems in personal care, general shopping, transportation, and household management. In all of these instances, the individuals for whom the case was resolved tended to be more impaired and dependent (Table 5.24).

Perpetrator Characteristics. None of the perpetrator variables were related to case resolution: age, sex, history of alcohol abuse and psychiatric institutionalization, availability of family members for support, someone to call in crisis, unrealistic expectations of the abused and dependency in financial resources (Table 5.23).

Situational Characteristics. Of the situational variables which were tested, household composition, type of abuse/neglect resulting in the report to the agencies, relationship of perpetrator to victim, perpetrator lives with victim, quality of the relationship between perpetrator and victim, household income and level of threat of the abuse or neglect, only one was significantly related to case resolution. Unresolved cases were more likely to involve physical abuse and less likely to involve active or passive neglect (Table 5.23).

Intervention Barriers and Strategies. Many significant relationships were found in this category. As would be expected, the Model Project staff encountered fewer barriers to intervention with the resolved cases (Table 5.25). The strongest differences were found in "receptivity of the persons" involved in the case. In 67.2 percent of the unresolved cases, receptivity of the abused hindered the intervention at least a little, compared to 25.2 percent of the resolved cases. Even more striking, the abuser receptivity was a problem in 80.9 percent of the unresolved cases in contrast to 31.9 percent of the resolved cases.

C. Summary

The results of the Case Re-assessment indicates that almost one-third of the cases seen by the Model Projects were resolved completely with some progress toward resolution noted for almost another third. While the underlying principle of practice for all the Model Projects was to try to maintain the family unit intact, it is interesting to note that changes in the living situation were made in almost half the cases, either through departure of the perpetrator or placement of the victim in the hospital, nursing home, or new living quarters.

TABLE 5.24 CHARACTERISTICS OF THE ABUSED/NEGLECTED ELDERS AND ABUSE SITUATION WHICH ARE RELATED TO CASE RESOLUTION

		Case Unresolved	Case Resolved
		# %	# %
a) Orientation to time	p=.02	n=54	n=166
A problem		4(7.4)	27(16.3)
Sometimes a problem		12(22.2)	58(34.9)
No problem		38(70.4)	81(48.8)
b) Dependency for transportation	p=.02	n=63	n=169
Independent		30(47.6)	49(29.0)
Slightly dependent		7(11.1)	15(8.9)
Very dependent		26(41.3)	105(62.1)
c) Type of abuse/neglect which precipitated report:	p=.008	n=71	n=195
Physical abuse		39(54.9)	66(33.8)
Psychological abuse		17(23.9)	44(22.6)
Material abuse		8(11.3)	33(16.9)
Active neglect		3(4.2)	18(9.2)
Passive neglect		4(5.6)	34(17.4)
d) Problem with personal care	p=.01	n=71	n=191
Yes		40(53.3)	141(73.8)
No		31(43.7)	50(26.2)
e) Problem with general shopping	p=.006	n=70	n=192
Yes		43(61.4)	152(79.2)
No		27(38.6)	40(20.8)
f) Problem with household management	p=.01	n=71	n=193
Yes		43(60.6)	149(77.2)
No		28(39.4)	44(22.8)

TABLE 5.25 DEGREE OF HINDRANCE OF BARRIERS TO DELIVERY OF APPROPRIATE SERVICES

		Case Unresolved	Case Resolved
		# %	# %
Coordination of Services	p=.003	n=52	n=137
Not hindered		41(78.8)	106(77.4)
Hindered a little		5(9.6)	6(4.4)
Hindered a lot		3(5.8)	-
No longer a problem		3(5.8)	25(18.2)
Receptivity of abused	p=.003	n=64	n=171
Not hindered		16(25.0)	67(29.8)
Hindered a little		19(29.7)	28(16.4)
Hindered a lot		24(37.5)	15(8.8)
No longer a problem		5(7.8)	77(45.0)
Receptivity of abuser	p=.000	n=68	n=162
Not hindered		8(11.8)	23(14.1)
Hindered a little		16(23.5)	21(12.9)
Hindered a lot		39(57.4)	31(19.0)
No longer a problem		5(7.4)	87(53.4)
Availability of services	p=.006	n=49	n=136
Not hindered		27(55.1)	63(46.3)
Hindered a little		11(22.4)	22(16.2)
Hindered a lot		7(14.3)	8(5.9)
No longer a problem		4(8.2)	43(31.6)
Lack of respite care	p=. 04	n=28	n= 80
Not hindered		15(53.6)	47(58.8)
Hindered a little		7(25.0)	5(6.3)
Hindered a lot		1(3.6)	8(10.0)
No longer a problem		5(17.9)	20(25.0)

To determine the factors which contribute to case resolution, two approaches were utilized. First, the case workers were given a list of intervention strategies and asked to record to what degree they had contributed to the resolution of the case. For the three Projects, the "changes in social/ living situation" was rated among the most effective and "changes in circumstances of the abuser which precipitated the abuse" as the least successful strategy. Generally, the Worcester staff tended to rate all interventions as more effective than either of the other two project, which is rather surprising since the Worcester Project has the largest proportion of cases in the resolved "not at all" plus "a little" category; this discrepancy may be due to the fact that there was a considerable portion of data missing on this question for the Worcester sample or differences in staff perceptions.

The second approach to the question was to identify the victim, perpetrator and abuse/neglect situation characteristics related to case resolution. For this portion of the analysis, a pooled sample was used after a comparison of the three case loads indicated that they were similar on almost all the sociodemographic variables. Very few characteristics turned out to be significant. Resolution was more apt to be identified with persons who were more dependent and victims of neglect than those who were less dependent and who were victims of physical abuse. Apparently, more success is possible in cases of neglect where the simple introduction of service or relocation to a nursing home can have a significant impact on the case. Leaving the elderly victim in a situation where the abuser is resistant to receiving help and where there is a mutual interdependency may be more difficult to resolve, especially if the abuser is a spouse. Further exploration into these issues and the nature and dynamics of elder is described in Chapter Six, an indepth analysis of selected cases drawn from the files of the three Model Projects.

CHAPTER SIX

INDEPTH ANALYSIS OF SELECTED PHYSICAL ABUSE CASES*

With additional funding from the AOA an in-depth analysis of physical abuse cases was undertaken to examine more closely the etiology of elder abuse. To distinguish it from previous research efforts, it would;

1) focus only on one type of maltreatment: physical abuse;

2) involve direct interviews with abused persons rather than relying on professional reports about cases;

3) incorporate a matched comparison group of non-abused elders; and

4) make an attempt to interview some perpetrators of elder abuse.

These characteristics are described in more detail below.

One additional extremely important aspect of this study is its exploratory nature. By this it is not meant that the study is an unfocused "fishing expedition." Rather as Schlesselman (1982) notes, it is one in which multiple hypotheses are proposed and investigated. The goal of such an effort is to learn enough about the phenomenon under study so that future research can deal with a specific hypothesis or hypotheses. Such a design is a more logical first step with elder abuse than is a study restricted to a specific hypothesis, for at present such a hypothesis could only be weakly supported. The effort undertaken here fits Schlesselman's description almost exactly:

> ...the characteristics of exploratory case-control studies are similar: (1) data concerning the distribution of potentially important characteristics among cases and controls are unavailable, and knowledge of the natural history of the disease is insufficient to justify study of a specific hypothesis; (2) an attempt it made to gather data concerning possible differences on a variety of factors among the cases as compared with the controls in the hope that etiologic clues worthy of further study will emerge (1982: 16).

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*The research described in this chapter was designed and carried out by Karl A. Pillemer for his doctoral dissertation. "Domestic Violence Against the Elderly: A Case Control Study. Brandeis University, Waltham, MA, 1984

Elder abuse is of course not a "disease," but can certainly be approached in this exploratory fashion. The ensuing description of the study methodology must be understood in light of its exploratory nature.

A. Methodology

Research Hypotheses

Five major areas which were identified in the previous chapter will be explored: evidence of "psychopathology" in the abuser; intergenerational transmission of violent behavior; dependency; external stress, and social isolation. The following hypotheses are to be tested:

1) Individuals who abuse elderly relatives will show a greater degree of mental illness or impairment than non-abusers.

2) Individuals who abuse elderly relatives will have been exposed more intensively to family violence in childhood than non-abusers.

3a) Individuals who abuse elderly relatives will experience more stress resulting from the dependency of that elderly person than non-abusers.
3b) Individuals who abuse elderly relatives will be more dependent on that elderly person than non-abusers.

4) Families in which abuse occurs will have experienced a greater amount of stress than those in which abuse has not occurred.

5) Families in which abuse occurs will be more socially isolated than families where abuse has not occurred.

Although (3a) and (3b) may seem contradictory, both are necessary, as mutual dependency may be a key element of elder abuse situations.

In the sections below devoted to data analyses, the specific ways in which these hypotheses were operationalized are discussed. Further, a secondary goal of this study is not explanatory, but descriptive; for example, the amount and type of violence is described. Thus, while the testing of hypotheses forms the core of this aspect of the Report, it is not the sole focus of it.

Sample Selection

Originally, this study was designed to interview 30 victims of physical abuse and the abuser in each case, and to match these 60 individuals with comparison, non-abuse cases. Although a number of factors changed this design somewhat, it still conforms to the basic features of a matched case-control study. Case-control studies involve a comparison between individuals who have a certain condition (cases) with individuals in whom the condition is absent (controls). The two groups are compared on certain pre-selected variables thought to be related to the condition under study (cf. Schesselman, 1982: 14ff.).

In the light of the preceding discussion, the need for such a control group design should be evident. Without a control group, as Pedrick-Cornell and Gelles have asserted, "one cannot identify factors associated with elder abuse" (1981: p. 25). It is necessary to contrast the characteristics of the abuse group with persons who do not resort to such behavior, in order to establish characteristics unique to abusive families. Clearly, it would be incorrect to refer to such a study as an attempt to identify causes of elder abuse. Rather, this design allows us to identify factors that are associated with abuse.

The abuse sample was selected from the client population of the three Model Projects on elder abuse. The study was limited to physical abuse cases for two reasons. First, as noted above in the literature review, there is reason to believe that various types of abuse and neglect should not be lumped together in one study. Recent studies by O'Malley, et al. (1983) and Giordano and Giordano (1984) have found some differences between victims of different kinds of maltreatment. Second, physical abuse is somewhat (although not absolutely) easier to identify than psychological abuse or neglect. From discussions with Model Projects staff, it became clear that perpetrators of material abuse would be difficult to locate and interview. Physically abused elders therefore constituted the sample.

Discussions were held with staff at the Model Projects to determine the availability of interviewees. They were very positive regarding the willingness of abuse victims to be interviewed, but felt it unlikely that the perpetrators of physical abuse would make themselves available. There were many abusers who were incarcerated, institutionalized in psychiatric hospitals, or unable to be located. Further, the Rhode Island Project was unwilling to arrange interviews with any of the abusers. They scheduled interviews with the elderly, and informed the researcher that he could arrange with the abused to obtain interview time with the abuser. From all three sites, it became apparent that it would be unlikely that the abuser and abused could be interviewed in each case.

This situation brought about a change in focus in the study. To take advantage of the situation as many abusers who were made available to me by the project staff would be interviewed, whether they were related to one of the abused or not. This would reduce the abuser component of the study to a special sub-analysis, rather than a primary component. It would also make impossible a comparison between the responses of abused and abuser in the same family, as only six of the thirteen abusers were related to the abuse victims to be interviewed. By increasing the sample size of the abuse victims, however, great statistical power could be added to the analyses. The final sample included 42 victims of physical abuse, and 13 perpetrators. The total of 60 interviews was not reached because the Worcester site (which had the smallest caseload) ran out of potential interviewees, and time and funding constraints made it impossible to travel to the other sites for additional interviews. One of the original abused interviews was discarded when it was determined that it did not represent domestic abuse.

One of the control interviews proved to involve physical abuse, and was substituted for it.

A major methodological consideration was the degree to which relying on staff to select the cases would bias the sample. In fact, this was a design element over which the researcher had no control, for the Model Project staff refused to participate in the study unless such control was given to them. It was agreed that the staff should screen the cases, as they were aware of situations in which an interview might disrupt the intervention strategy or even precipitate abuse. However, it was possible that staff might exclude the most frail elderly and the most dangerous or troubled families from the analysis. To avoid this, the staff was repeatedly requested not to systematically exclude difficult cases.

There was evidence that the abuse sample did not differ from the total abuse population in any significant way. First, the staff they believed that the cases represented a cross-section of physical abuse cases. Second, over half of the physical abuse cases available at the time were interviewed. Finally, when the sample which was interviewed was compared with the total sample of physical abuse cases seen by the projects throughout the course of the study, no significant differences ($p<.05$) were found on age, marital status, race, income, or living arrangement using the chi square test. For these reasons, it is reasonable to assure that the sub-sample studied here is representative of the total sample included in the larger study.

The next methodological issue to be resolved was the selection of a non-abuse comparison group. The major task was to find a control case for each of the 42 abused elders. The optimal strategy in such a case would have been to select a set of control respondents in each site. For example, one could attempt to interview the nearest neighbor who meets the study characteristics. Alternatively, non-abuse cases from social agencies at each site could have been selected. However, time and financial constraints again rendered such a design impossible. Fortunately, arrangements were made with the agency in which the Worcester project was located: Elder Home Care Services of Worcester (EHC). They agreed to allow the control group to be drawn from their caseload.

Members of the EHC comparison group were individually matched with members of the abuse sample. There were two primary criteria for the matching: sex and household composition. The only consistent findings thus far in the literature regarding physical abuse of the elderly are that victims of this type of maltreatment tend to be female, and to live with the abuser. The issue of living arrangement was more critical than sex: roughly half of EHC clients live alone, while all but three of the abuse sample live with the abuser. In order to insure the similarity of the samples (and thus the plausibility of the study) matching needed to take place.

After the interviews with the abused elders had been completed, a strategy was derived for the selection of the comparison group. To make the selection of controls as random as possible, and to avoid being given case managers' favorite and most cooperative clients, a meeting was arranged with all the case managers, and the specifications concerning sex and living arrangement for one or two clients (e.g., "female, living with son") presented to them. The case managers were asked to select the client who had joined their caseload most recently, who met the criteria. They then were to call the client and attempt to schedule an interview. If the client refused, then the case manager was to procede to the next most recent client. Finally, the case manager would give the researcher the name and telephone number of the client, and a call made for an interview.

Surprisingly, this cumbersome process worked very smoothly. In a few unusual cases, a general announcement had to be made to the case managers to find a comparison case: one such case involved a woman living with her "gentleman friend" and daughter. Once contacted, very few persons declined the interview (see section on "Interview Process," below).

In this fashion, 42 matches for the abused individuals were obtained. The question then arose: How could controls for the 13 abusers be obtained? Two options were possible. First, the case managers back could check their caseloads, select 13 children or spouses of clients, and contact them. Alternatively, the elderly control group already interviewed, could be contacted to find out if they would make their kin available. The latter course was chosen as the simplest and least time-consuming. Further, the case managers were nearing the end of their tolerance for the research activities. Thirteen individuals were selected from the larger control group using a random numbers table, and became the comparisons for the abusers.

The entire study sample therefore consisted of 110 individuals: 42 physically abused elders, 13 perpetrators, 42 non-abused control elders, and 13 relatives of the control elderly who served as controls for the perpetrator group.

Before proceeding, one further issue must be discussed: what were the criteria employed for labeling a client "physically abused," or "non-abused?" For the abuse sample, it was the Model Project case workers' assessment that at least one physically violent act had taken place since the inception of the Project (that is, of the time of the interviews, within the preceding two years). This act could range from throwing an object at the other person to assaulting them with a knife or a gun. As discussed below, the abuse workers were asked to complete a detailed scale regarding the amount and type of violence that they were able to verify had occurred in each case.

Similarly, the EHC case managers were relied upon to identify clients who had not experienced physical abuse. As with most case-control studies, however, cases were uncovered in which some physical abuse had occurred. In one case, a substantial amount of violence had occurred in the preceding year; that individual was transferred to the abuse sample. In two additional cases, violence had not occurred so recently, but had taken place since the victim became "elderly" (by my definition, 60 or over). These two cases were replaced as well, to avoid any contamination of the comparison group.

Interview Design

The design of the two interview protocols for the elders and kin was a lengthy process. Several previously used protocols, such as those by Archbold, Cicirelli, Sengstock and Liang, and others were reviewed. Simultaneously, the staff of the Model Projects were consulted, they gave invaluable guidance in the design, based on their "front-line" experience, as did the members of the University of New Hampshire's Family Violence Research Program. Some of that group's expertise in interviewing abuse victims was incorporated into the design. This process resulted in two distinct but overlapping questionnaires of approximately 45 pages in length. Nine pretest interviews were conducted with six elderly persons and three family members. The pre-test led to some minor modifications in layout and content, but the protocol remained largely unchanged (Appendix I, Exhibits 4-5).

A few general comments about the interview instrument may be helpful here. First, it was a major goal of this research to integrate quantitative and qualitative components in its design. For this reason, the interview contained both closed-ended and open-end questions. Various scales were used to test quantitatively the hypotheses laid out above, but many opportunities for qualitative description were offered, and responses recorded. Thus, for example, a scale of stressful life events was employed, but only after the respondent had been asked: "What do you find stressful in your life right now? What do you tend to worry about?" Second, this qualitative approach was carried further in six tape-recorded interviews conducted as follow-ups to the first interview. Three abuse victims and three abusers were interviewed for roughly an hour. These were then transcribed in their entirety. Third, each interview began with an informed consent statement. This contained a description of the study and assurances of confidentiality. Because of the sensitive nature of the study, it was anticipated that respondents might be unwilling to sign an informed consent statement. Therefore, each form certified that the respondent had understood and agreed to participate.

Interview Process

There was a question from the beginning stages of the research whether the individuals involved in abuse situations would agree to be interviewed. In addition, there was doubt whether the EHC clients would agree to take part. As it turned out, most of the individuals contacted were very willing to participate. This high level of compliance was probably due to a number of factors. Elderly, in general, have been found to have high rates of response to surveys. Also, the Model Project workers and EHC case managers had developed trusting relationships with many of the clients. They were thus able to secure entry for me more effectively than I might have done on my own. Furthermore, each respondent was paid $10.00 in cash for their participation. It should be noted that the respondents were informed of the payment initially by the worker, and then again at the beginning of the interview. They were not asked to sign anything, or to receive a check. This streamlined the payment process, and put respondents at ease.

In retrospect, it is unclear how necessary this payment was. A few interviewees expressed gratitude for it, but many noted that they would have participated without reimbursement. A substantial number tried to refuse the payment, and a few even seemed resentful that it was offered. Without a systematic test, there is no way of ascertaining whether the payment actually increased compliance. Taking into consideration the mixed and often negative response to the payment, it seems advisable to omit it in a later study.

The abuser sample was, as noted above, much harder to obtain, primarily due to the inability or reluctance of Model Project staff to contact the abusers. Frequently, the perpetrator was unknown to the case worker. In other cases, the abuser was institutionalized, incarcerated, or in some unknown location. In some cases, the Model Project workers feared that the interview might disturb the abuser, and lead to further violence. The result of this unsystematic selection process led to a skewed sample of abusers; this is discussed in the section below on the abuser sample.

To obtain the data on the victims, interviews were scheduled 10 days at each site. The interview itself could be completed in about 45 minutes, but generally lasted about one and a half hours. This was due to the informal conversation which took place at the beginning of the interview to put the respondent at ease, and to the lengthy answers to open-ended questions that were frequently forthcoming. In very few cases were the abused respondents reticent about discussing the situation: frequently, they would launch into a narrative about the abuse before there was time to read them the informed consent statement.

It may seem that an average of two completed interviews per day is rather low. In addition to the interviews, there was a number of other activities that had to be completed. In almost every case, the client's situation was discussed with the Model Project worker for approximately 30 minutes. Travel time was often extensive, as the projects covered large geographical areas. After each interview, the researchers generally spent 30-60 minutes writing a description of the case and filling in qualitative responses. The comparison interviews took less time to complete; three or four could be done per day. Since abuse was not present, the interviewees generally had fewer salient anecdotes to offer, and tended to answer questions in a more straightforward fashion.

With both the abuse and non-abuse cases, the researcher was conducted to the house and introduced by the Model Project worker or case manager. The respondent was asked in every case if they would prefer the worker/case manager to remain for the interview. The staff felt that this option was necessary, and believed that many clients would not consent to the interview if the worker were not allowed to be present.

Further, there was a simple logistical problem: where would the worker, go during the time the interview was taking place? An agreement was reached to allow the workers to be present.

This eventually turned out to be a major strength of the study. However, it was initially difficult. There was a tendency in some instances for the workers to answer for the client and even fill in for them when they paused. Long and frank discussions were held with the staff, and the need for the respondent to answer independently. After the interview was completed, there was an opportunity for the staff to fill in factual information. It was stressed that they were not to provide it during the interview. In the end, an excellent relationship was developed between the researchers and the staffs that made them eventually an asset in the interview process. The staff person was allowed them to prompt the respondent; that is, too show them that it was all right to be honest with me. For example, a respondent, when asked if her husband ever hit her, might reply "no, not really." The staff person would then remind her of an incident that the respondent had described. This often led to an open discussion of the abuse.

The presence of the staff person helped to solve another difficult methodological problem. Many of the respondents (like many low-income elderly) lived in small houses or apartments where privacy was at a minimum. It was therefore difficult to interview the abused or control client out of the presence of the family member. This was compounded by the fact that the researcher was a young male interviewer talking with an almost entirely female elderly sample. This made the suggestion that they go into one of the bedrooms to conduct the interview uncomfortable for the respondents. In general, the children of the respondents were willing to absent themselves, while the spouses were often unwilling.

On occasions where there was no other alternative, the case workers arranged to "interview" the other member of the couple. The researcher would introduce himself to the respondent, and say that the case worker wished to speak to her partner. They would go to another room, and thus the abused would be free to be interviewed. In the control cases, the case managers usually did not stay for the entire interview; they would introduce the researcher and leave. In some of these instances, both the respondent and her partner refused to be separated for the interview. In those cases, the other person was allowed to remain, since the only alternative would have been to end the interview.

The most striking aspect of the interview process was the willingness of the abused elderly to talk about the maltreatment. At some point in nearly all of the interviews, the person would embark on a narrative of what had happened, often in graphic detail. It was usually unnecessary to prompt them once begun. In the tape-recorded follow-up interviews, some of the flavor of these descriptions were captured on the tape. When the interview concluded, the contents would generally be discussed with the case worker. The workers were then invited to fill in gaps in the data; in two cases, in which the client was a difficult respondent, but very well-known to the case worker, the latter completed fairly extensive parts of the form. The researcher then write his own comments on the case, and fill in additional descriptive information.

Data Processing and Analysis

All of the data were collected by April, 1984. With the collaboration of a research assistant, the data were coded for entry on the computer. Much of the coding was straightforward and required no judgement on the part of the coder. A few of the qualitative questions were coded into categories: after training, the assistant coded these and her decisions reviewed in every case. Two separate files were entered into the computer: one with the abused elderly and comparisons, and the other with the perpetrators and comparisons. These data were analyzed using the Statistical Package for the Social Sciences.

Statistical procedures employed were selected to identify significant differences between the abuse and non-abuse groups. One major focus on this study was to explore the etiology of elder abuse: to ascertain ways in which the groups differed in the five areas discussed above. Because of the small size of the sample and the exploratory character of the study, complex multivariate models such as logistic regression were deemed inappropriate. Three statistical tests are used most frequently in the subsequent analysis: the Wilcoxon matched-pairs signed-ranks test, the McNemar test for the significance of changes, and the t-test for related samples. All three of these tests specifically take into account the matched control-group design. Much of the data analyzed here are ordinal data, which are appropriate for the Wilcoxon test. Two-by-two tables are analyzed using the McNemar test, and interval data using the t-test. Throughout, the significance level is the conventional .05, although on occasion results that approach, but do not meet, this level of significance are discussed. The chi square test was used in a few special instances.

The qualitative data on the interview forms were transcribed in their entirety, as were the six tape-recorded interviews. This resulted in approximately 300 pages of transcribed material. Using a simple coding system, the material was categorized into the the five basic hypothesis categories - stress, isolation, etc. - as well as a few other groupings, including the consequences of the abuse for the victim, actions taken when abuse occurs, and the victim's reasons for remaining in the relationship. These qualitative data are employed throughout to shed additional light on the qualitative findings.

Abuser Sample

The manner in which the abuser sample was selected, and why it was originally included in the design have been explained alone. Unfortunately, after the data had been collected it was decided that the quantitative findings from the abuser sub-sample could not be used principally, because it was a highly skewed sample. It was not possible to interview the impaired, dependent perpetrators who made up most of the sample (see below). They made themselves scarce at the time of the interview, and there was no legitimate way of seeking them out. Some, too, were incarcerated or otherwise institutionalized. The 13 abusers consisted almost entirely of spouses (9), who were primary caretakers. In many of these cases, it was uncertain as to whether abuse had actually occurred. Because of these factors, as well as questionable selection process used to select the abuser control group and the sample size, the abuser sub-sample was dropped as a separate focus in this study.

B. Descriptive Overview

With a few exceptions, these data indicate that the abused and non-abuse groups are generally similar.* As the respondents were matched on sex, equal numbers of men and women are present in both groups: 39 women and 3 men. In both groups, the relationship of the abuser or comparison relative to the elder were identical: 14 (33 percent) sons; 14 (33 percent) husbands; 10 (24 percent) daughters; 2 (5 percent) daughter-in-laws; and 2 (5 percent) brothers. A number of other variables are presented in Table 6.1 which describe various characteristics of both samples. Both samples are almost entirely white. Over two thirds of the two samples did not complete high school, and almost exactly equal proportions are married, or widowed. Although the abuse group tended to have higher incomes, respondents' incomes in both groups tended to be low: over 76 percent of the abuse group and over 88 percent of the controls had incomes of less than $6,000 per year. Respondents in both groups tended to be Catholic (roughly 70 percent).

No significant differences were found between the groups in the length of time in the reported marital status, number of years at the same address, total number in the household, or number of rooms in the dwelling. One significant difference was found, however: the average age of the abuse group was significantly lower than that of the controls (p=.021). This resulted primarily from the fact that three individuals under the age of 60 into the abuse group (ages 55, 56, and 57). Because these persons were seen by the Model Project staff and thus a part of the program, and because they were "elderly-like" individuals, they were included Specifically, these three persons were among the most severely impaired in the sample: one was bed-bound with multiple sclerosis; one was largely confined to bed with emphysema, and one was a wheelchair user as a result of a stroke. It is of course impossible to be certain that any two samples are similar. As the above data indicate, the background characteristics of these groups do not differ significantly, to the degree that they would contaminate the results to be presented below.

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*From this point on, the discussion refers only to the sample of 42 abuse victims and the matched controls. The abuser sample and controls are discussed separately in section .

TABLE 6.1 COMPARISON OF CASES AND CONTROLS

	Abuse Group	Non-Abuse Group
	# %	# %
a) Race		
White	41(97.6)	40(95.2)
Black	1(2.4)	1(2.4)
Hispanic	0	1(2.4)
Wilcoxon: N.S. (Not Significant)*		
b) Education		
0-6 years	10(23.8)	8(19.0)
7-9 years	15(35.7)	21(50.0)
Some high school	5(11.9)	4(9.5)
High school graduate	2(4.8)	3(7.1)
Some college or vocational training	10(23.8)	5(11.9)
College graduate	0	1(2.4)
Post-graduate study	0	0
Wilcoxon: N.S.		
c) Marital status		
Single (never married)	1(2.4)	2(4.8)
Married	18(42.9)	19(45.2)
Widowed	20(47.6)	18(42.9)
Divorced	2(4.8)	2(4.8)
Separated	1(2.4)	1(2.4)
Wilcoxon: N.S.		
d) Respondent's income		
Less than $2,499	7(18.4)	11(30.6)
$2,500 - $5,999	22(57.9)	21(58.3)
$6,000 - $9,999	7(18.4)	4(11.1)
$10,000 - $14,999	1(2.6)	0
$15,000 - $19,999	0	0
$20,000 - $24,999	1(2.6)	0
(missing cases)	4	6
Wilcoxon: N.S.		

*Unless otherwise indicated, the values agive are for two-tailed probability.

TABLE 6.1 COMPARISON OF CASES AND CONTROLS (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
e) Religion		
Catholic	30(71.4)	29(69.0)
Protestant	11(26.2)	10(23.8)
Jewish	1(2.4)	1(2.4)
Other	0	0
Chi Square: N.S.		
f) Age		
Mean Age	70.5	75.2
t-test:* p=.021		
g) Years in marital status		
Mean Years	25.9	31.8
t-test: N.S.		
h) Years at same address		
Mean Years	14.9	20.7
t-test: N.S.		
i) Total number of persons in household		
Mean number of persons	2.5	2.4
t-test: N.S.		
j) Number of rooms in dwelling		
Mean number of rooms	5.3	5.1
t-test: N.S.		

C. Nature and Extent of Conflict and Violence

> "I feel sad for poor old people. They are never believed. People didn't believe me.*

The notion of physical abuse of the elderly is a disturbing one to many people, and, like child and spouse abuse, disturbing phenomena are frequently denied. Alternatively, it may be assumed by some that this type of physical violence is so aberrant and pathological that it must happen only in obviously disturbed families, and not "next door." Even those who are familiar with the literature on family violence may have difficulty conceptualizing the circumstances in which the elder abuse occurs. Because of the relative strangeness of the phenomenon of elder abuse, this chapter begins with a set of case studies of violence. These examples have been selected to give a graphic picture of what domestic violence against the elderly looks like. Also cases have been chosen to show the wide range of actions that are grouped under the term "elder abuse." This will set the stage for the data analysis which follows.

Case I

Mr. A is a 64 year-old man who lives with his wife and 22 year-old son in the second floor apartment of an old three-decker building. He has multiple sclerosis, but is still ambulatory and is able to drive a car. When the interviewer arrived, he was tidying up as best he could around the small apartment. However, he is often quite weak and unsteady on his feet. His mobility is also hindered by the fact that he is overweight.

Mr. A has been the victim of physical abuse by his son, Edward, for about three years. Edward had been discharged from the Marines after having what his father termed a "nervous breakdown." Edward is extremely imposing physically; tall and massively obese, he is estimated by the Model Project worker to weight around 300 pounds. He became very violent during his breakdown and, his father attested, "had to be held down by five marines." Although he has never been an easy person to get along with, this breakdown and discharge made him much worse. Since then, he has been repeatedly hospitalized for psychiatric reasons. He has been married and divorced to another former mental patient, and at the time of the interview was living with a prostitute and her children.

Mr. A reported that Edward comes by the house almost every day, in spite of the fact that Mr. A has obtained a restraining order to prevent such visits. Mr. A finds these visits almost uniformly unpleasant. They generally involve requests for financial assistance. To quote from the interview:

> Mr. A: He's always demanding, you know, money. Money is the root of all evil. That's what it is, money and cigarettes and what-not.

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*The quotation that begins this chapter and the following ones come from interviews with abused elders.

Interviewer: So when's the last time he asked you for money?

Mr. A: Well, let's see....yesterday.

Interviewer: And what happens? What did he say?

Mr. A: Well, he needs a couple of dollars for gas or something like that, you know. To get him off your back you give him a couple of dollars, you know. A dollar buys cigarettes, or milk, or something.

Interviewer: And you give it to him?

Mr. A: Well, so like I say —my wife gives it to him so we don't have, you know what I mean, trouble. To get him off our back. Hey, you want to sleep. He comes at night.

Interviewer: What happens if you don't give it to him?

Mr. A: He starts kicking stuff around...he has also assaulted me three times. He hit me in the head, and on my body, and knocked me down. He takes off when we call the police but always comes back.

When asked why he doesn't bar Edward from the house and totally break off contact with him, Mr. A responded that he was afraid of his son:

> Because the way he acts and comes in here and banging at the door, going to knock my door down. I don't want him disturbing the peace. I've got tenants upstairs and downstairs, and so not to make a scene I let him in. It's just a case of where I'm handicapped and if I ever start fighting with him, I'd probably be hurt bad...in other words, I can't defend myself...I don't go looking to fight with him because it's like a hornet's nest. If he goes off, off his faculty he could really hurt me bad. Which I don't want; I'm hurting enough.

Mr. A did not see any solution to his situation. He is unwilling to abandon his son entirely or have him arrested, nor does he wish to leave his home and move to elderly housing, where he would be more protected. At the time of the interview, Mr. A noted that the violence had stopped, due to the intervention of the Model Project worker. The worker had threatened police intervention, and this frightened Edward. In the long run, however, Mr. A did not envision any permanent resolution:

> I just hope to God that, like I say, there's peace in the house. That's what I want, and I'm looking forward every day that things will be corrected. That's the size of it, and I just hope nobody has to go through what we are going through, my wife and my family. It's something - it's your own flesh and blood. I'm looking for an answer, and I just hope to God that there's an answer someplace in the near future.

Case II

Mrs. Y was one of the saddest and most disturbing interviews which were conducted. She and her husband live in a small house in a working class neighborhood. The interviewer was shown in by Mrs. Y's close friend and neighbor. Walking in, through the darkened living room, a slumped form could be seen in an easy chair. Before leaving the room, the form emitted a long, gutteral groan that made the interviewer jump. This was Mrs. Y's husband, a victim of Alzheimer's disease. Throughout the interview, which took place in an adjoining room, grunting and shouting and occasionally pacing back and forth could be he heard.

The interview with Mrs. Y took place in what had once been the dining room, and now served as her bedroom. She lay in a hospital-style bed, with her hands limply akimbo. She was in the late stages of multiple sclerosis, and could only move her head and neck; otherwise she was totally paralyzed. She is assisted by the visits of home health aides, a woman she hires on weekends, and the neighbor who had brought me in. She has been bedridden for three years. Her husband, as she put it, began to get severely "senile" in 1979, and had to stop working.

Mrs. Y asserted that before the onset of Alzheimer's disease, her husband was "a saint." She reported, "He was quiet, fussy about his clothes, modest, shy. We had a good relationship. He was never violent." Now, she said, he is argumentative and angry. She tries still to talk with him, but generally receives little response. At times, he becomes extremely agitated, and has hit her. The most recent incident, and the one that influenced her to contact the Model Project, was for her terrifying:

> I was saying something to him, and he got angry. He put his hands around my throat and started to choke me. There was nothing I could do. I started to cry and then he stopped. He saw the tears in my eyes, and stopped.

Mrs. Y attributed the abusive behavior to her husband's illness, which she said had transformed him. She was extremely reluctant to institutionalize him, however. She asserted that nursing homes are "bad," and that it would be a betrayal to place him in one. She reported a sense of obligation to him for his past kindness to her. Again, this is a situation without any clear prospect for resolution until the deteriorating physical condition of the two partners necessitates a change in living situation.

Case III

Mrs. N, a 78-year old woman, was assaulted by her adopted son Greg. Greg wsa the illegitimate child of Mrs. N's daughter, and thus her natural grandchild. The daughter contracted German Measles during her pregnancy and Greg was born profoundly deaf and mildly retarded. The daughter was too unstable to care for him, and he was legally adopted by his grandmother. He is now 28, and has had little contact with his natural mother. He works full-time as a custodian at a nearby college.

Mrs. N described her relationship with Greg as "wonderful" until the past year. "We were pals," she reported. "I used to ask him, 'Why don't you get married?' He said 'I'll stay with you.'" They both were regular attenders of a deaf club, where Mrs. N was made an honorary member. Greg had always been kind and solicitous to her, and helped her as much as possible. This changed a number of months prior to the interview.

The event that precipitated the abusive incident was the development of a relationship between Greg and a gay deaf man in the club. As Mrs. N described it:

> In May I found out he was going gay. I went to the club and there was this man all over him, trying to turn him gay. I left the club and walked home. They like me at the club, and when I left, they told Greg to go home to me. I said he would have to leave and he walked out. Then he came back on Sunday, and got so angry! He had come for his clothes. He pushed me in the face, like this, and I fell down and split my lip.

Mrs. N obtained a court order to prevent her grand son from returning; he stayed away for two months. They would meet periodically at the deaf club, however, and he would plead with her to allow him to come back. She refused, for while she had forgiven him for the violence, she could not accept a gay relationship. However, she said:

> Then I talked to my priest. He said I should take him back, that it wasn't so bad to be gay. I said to myself, here is a Jesuit priest, and he is not so upset, so why should I be?

She offered him the chance to move back if he would at least stop the "gay part" of the relationship while he lived with her. "So, he wrote on his slate 'No more gay' and I took him back home." She reported that no further violent incidents have occurred, and that the relationship is as good as it once was.

Case IV

Mrs. D lives in a moderately-sized, attractive house in a pleasant suburban neighborhood. The interview took place in her living room, looking out through a large picture window over her lawn to houses beyond. Many of her relatives live nearby; she was able to point her brother's house out to me from the window. Mrs. D is a very lively and animated woman; who speaks with a slight Italian accent. When animated, she seemed much younger than her 70 years. She now lives with her son, Alan, and grandson; until their recent separation, her son's wife and two more grandchildren resided with her. The daughter-in-law, Edna, was repeatedly abusive to Mrs. D.

As she told the story, Alan met Edna upon discharge from the service twelve years ago. She became pregnant, and the couple, in Mrs. D's words, "had to get married." She invited them to reside with her until they "could get on their feet." "I said, 'I got this house over here,' and when they got married, they came and lived over here. Oh God! From the first night, screaming, yelling -everything had to be her way." Rather than ask them to leave, Mrs. D had part of the upstairs of the house remodeled into an "in-law" apartment and left the remainder of her house to her son and daughter-in-law. She did not ask them for any rent or other financial assistance.

Although she acknowledged that her daughter-in-law sometimes was pleasant to her, the conflicts were many. Mrs. D was heavily involved in caring for the children, especially in the last few years when both parents worked. She is extremely attached to her grandchildren, and refers to them frequently in conversation. Edna was dependent on her for child care, but also argued violently with her about them. They also fought about the house; Edna wanted Mrs. D to turn it over to her. Towards the end of the relationship with her husband, Edna began to drink more heavily, and to have affairs with other men.

During this last period, a series of violent events occurred between Mrs. D and Edna. It is worth quoting Mrs. D at length, to give an example of a victim's account of maltreatment.

> She came upstairs. I was making Christmas gifts, stuffed toys for the kids. She cam upstairs and she told me to tell my son that they didn't need me as a babysitter anymore. So I said "fine." I said "Look, I'm not going to tell him. You want to tell him, there's the phone. Call him." That's all I said. Well! Because, see, I wasn't doing what she wanted me to do, so she came up to me near the sewing maching. "You tell him or else." I said, "I told you I am not." And she said to me - see, she's got this sister-in-law who got divorced. It was bad. She says, "If you think that divorce was bad, you wait and see what I'm going to do." So then I said, "Well, what is it that you're going to do?" "Well," she said, "I'll show you."
>
> She she grabbed me. She scratched me all over here. All scratches, and she pulled me off of the chair where I was sitting near the sewing machine. She pulled me off. Well, when she did that, I grabbed her hair. I said, "You're not going to do that to me." Well, when I grabbed her hair, she slapped me and threw me across my kitchen there, and I went against the refrigerator and I lost my balance. When I lost my balance, she thought I was having a heart attack, see? She saw me go down, and she said, "Ahh, she's having a heart attack." She said, "Have a heart attack! Now, have a heart attack! You have a heart attack, now!"
>
> When I regained my balance - I got a counter upstairs -I said to her, "How can you do this to me when I was so good to you?" I said, "I was even better to you than my own daughter," which is true. And she leaned across the counter and she spit right in my face. and I had an ashtray on there. She grabbed that ashtray and threw it, but that ashtray swayed. Instead of coming towards me, that ashtray went against the window, but it didn't break. Then she went downstairs.

Mrs. D then called her sister-in-law, who urged her to call the police. Edna clained to the police that Mrs. D had assaulted her. In the absence of witnesses, no charges were filed. However, Mrs. D contacted the Model Project staff person, who visited her. Mrs. D did obtain a restraining order against the daughter-in-law, who left shortly after the incident. Divorce proceedings began, and Mrs. D's life became more settled. She worries almost constantly about the grandchildren who live with her daughter, and tries to see them as often as she can.

Four different cases of domestic violence have been presented in which an elderly person was the victim. They range in seriousness from a single incident to an on-going pattern of routine abuse. They involve a son, a husband, an adopted grandson, and a daughter-in-law. Ostensibly, the connection between these cases may appear to be few: the obvious common thread is the violent act. In subsequent sections of this chapter, an attempt will be made identify elements in the abusive families that distinguish them from non-abusive ones, and thus to uncover factors specifically associated with abusive behavior to elders. In the remainder of this section, however, the concern is with the violence itself: What happened? How frequently did it occur?

Measuring Conflict and Violence

As noted above, one goal of this study was descriptive: to ascertain the degree and type of intrafamily conflict in the abusive families. In order to do so, the Conflict Tactics Scale (CTS), developed by Murray Straus of the University of New Hampshire, and further refined over the years by Straus and his colleagues there (Straus, 1979; 1982)) was employed. As Straus has noted, methods of dealing with a family conflict are almost infinite, and only open-ended questions can adequately tap every possible response. However, Straus defends the use of a scale in the following way:

> But, in practice, the way people deal with conflict is so much a part of the unrealized "taken from granted," ongoing pattern of life that much will be missed unless the respondent is specifically asked. Other omissions occur because certain tactics, such as the use of physical force-although extremely common-may be pushed out of memory because they are unacceptable presentations of the self (1979;77).

For these reasons, in all but an intense, in-depth interview, some structured method is highly useful. The question then arises: What specific conflict tactics should be included in a structured scale? The CTS includes three different types of tactics (see Appendix I, Exhibit 4, p.34). Items a, b and c form the "reasoning" scale, that is the use of rational, intellectual approaches to settling a dispute. Items d, e, g, h, i and j make up the "verbal aggression" scale. These acts, according to Straus, actually involve both verbal and non-verbal acts designed to hurt the other, such as threats. The "violence" scale is formed by items k through r, actions which involve the use of physical force to resolve a conflict. Using the CTS, three analyses will be included:

1) the degree of violence in the abused group will be identified

2) the cases and controls will be compared on the amount of verbal agression

3) the assessment of the level of violence by the project case workers will be compared with that of the respondents themselves.

Violence in the Abused Group

It is meaningless to compare the rates of physical violence between comparisons and controls, as the control group was specifically selected because no physical violence had occurred. However, it is important to describe the violence experienced by the abusive families. Table 6.2 presents data from the CTS, as reported by the elderly respondents. In the year preceeding the interview, 40 percent had had something thrown at them, 56 percent had been pushed, grabbed, or shoved, 40 percent had been slapped; and 31 percent had been kicked, bit, or hit with a fist. More seriously, 17 percent had been hit with something; 7.1 percent had been beaten up; and 9.5 percent had been threatened with a knife or a gun. None of the elders reported having been actually assaulted with a knife or gun.

The question then arises: Was this violence unreciprocal, or was it mutual? As Table 6.2 shows, the elderly respondents reported having committed far fewer violent acts. None admitted to throwing something, hitting with something, beating up the other, or using a knife or gun. One person reported having threatened the relative with a knife or gun, and two had either slapped the other or kicked, bit, or hit with a fist. Three persons had pushed or shoved the relative in the previous year.

Clearly, it is possible that a certain degree of underreporting may take place with questions such as these. Even if the figures in Table 6.2 are taken at face value, the elderly in the sample experienced a considerable amount of physical maltreatment. This is even more apparent when the number of occurrences is taken into account: for example, nine persons had been pushed, grabbed, or shoved 11 or more times in the preceeding year, and six had been slapped or had something thrown at them that frequently.

Comparison of Verbal Agression

It is of interest to explore whether the non-abuse group was less likely to engage in conflict tactics other than those involving physical violence. It might be that of non-abused elders are subject to verbal abuse to the same degree as abused elders, but that this aggressive behavior stops before the violence occurs. Table 6.3 compares the two samples on the elders' report of the incidence of verbal aggression on the part of their relatives. With the exception of sulking or refusing to talk, the victims of physical abuse were much more likely to experience verbal agression. The intensity of verbal

TABLE 6.2 VIOLENCE EXPERIENCED IN THE PAST YEAR*

	Relative	Elder
	# %	# %
a) Threw something		
Never	21(50.0)	32(92.9)
Once or twice	7(16.7)	0(0.0)
3-10 times	4(9.5)	0(0.0)
11 or more times	6(14.3)	0(0.0)
Unknown/No answer	4(9.5)	3(7.1)
b) Pushed, grabbed, or shoved		
Never	12(28.5)	34(80.9)
Once or twice	8(19.0)	0(0.0)
3-10 times	7(16.7)	3(17.1)
11 or more times	9(21.4)	9(0.0)
Unknown/No answer	6(14.3)	5(11.9)
c) Slapped		
Never	19(45.2)	37(88.1)
Once or twice	6(14.3)	0(0.0)
3-10 times	5(11.9)	2(4.8)
11 or more times	6(14.3)	0(0.0)
Unknown/No answer	6(14.3)	3(7.1)
d) Kicked, bit, or hit with fist		
Never	23(34.7)	36(85.7)
Once or twice	7(16.7)	1(2.4)
3-10 times	2(4.8)	0(0.0)
11 or more times	5(11.9)	1(2.4)
Unknown/No answer	5(11.9)	4(9.5)

TABLE 6.2 VIOLENCE EXPERIENCED IN THE PAST YEAR*(cont.)

	Relative	Elder
	# %	# %
e) Hit or tried to hit with something		
Never	29(69.1)	39(92.9)
Once or twice	3(7.1)	0(0.0)
3-10 times	3(7.1)	0(0.0)
11 or more times	1(2.4)	0(0.0)
Unknown/No answer	6(14.3)	3(7.1)
f) Beat up		
Never	35(83.3)	39(92.9)
Once or twice	3(7.1)	0(0.0)
3-10 times	0(0.0)	0(0.0)
11 or more times	0(0.0)	0(0.0)
Unknown/No answer	4(9.5)	3(7.1)
g) Threatened with knife or gun		
Never	36(85.8)	39(92.9)
Once or twice	4(19.5)	1(2.4)
3-10 times	0(0.0)	0(0.0)
11 or more times	0(0.0)	0(0.0)
Unknown/No answer	2(4.8)	2(4.8)
h) Used knife or gun		
Never	40(95.2)	40(95.2)
Once or twice	0(0.0)	0(0.0)
3-10 times	0(0.0)	0(0.0)
11 or more times	0(0.0)	0(0.0)
Unknown/No answer	2(4.8)	2(4.8)

*Percentages may not equal 100 percent due to rounding.

TABLE 6.3 COMPARISON OF VERBAL AGGRESSION EXPERIENCED BY ELDERS IN PREVIOUS YEAR

	Abuse Group	Non-Abuse Group
	# %	# %
a) Relative insulted or swore at elder		
Never	6(14.3)	34(80.9)
Once or twice	0(0.0)	1(2.4)
3-10 times	2(4.8)	3(7.1)
11 or more times	27(64.3)	3(7.1)
Unknown/No answer	7(16.7)	1(2.4)
Wilcoxin Test:		
b) Relative sulked or refused to talk		
Never	22(52.4)	33(78.6)
Once or twice	0(0.0)	1(2.4)
3-10 times	0(0.0)	4(9.5)
11 or more times	16(38.1)	3(7.1)
Unknown/No answer	9(21.4)	1(2.4)
Wilcoxin Test:		
c) Relative stomped out of house, room, or yard		
Never	13(31.0)	32(76.2)
Once or twice	1(2.4)	2(4.8)
3-10 times	8(19.0)	3(7.1)
11 or more times	12(28.6)	4(9.5)
Unknown/No answer	8(19.0)	1(2.4)
Wilcoxin Test:		

TABLE 6.3 COMPARISON OF VERBAL AGGRESSION EXPERIENCED BY ELDERS IN PAST YEAR (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
d) Relative cried		
Never	25(59.6)	39(92.8)
Once or twice	1(2.4)	2(4.8)
3-10 times	3(7.1)	0(0.0)
11 or more times	7(16.7)	1(2.4)
Unknown/No answer	6(14.3)	0(0.0)
Wilcoxin Test:		
e) Relative did or said something to spite elder		
Never	14(33.3)	39(92.8)
Once or twice	0(0.0)	1(2.4)
3-10 times	4(9.5)	1(2.4)
11 or more times	15(35.7)	0(0.0)
Unknown/No answer	9(21.4)	1(2.4)
Wilcoxin Test:		
f) Relative threatened to hit or throw something at elder		
Never	17(40.5)	42(100.)
Once or twice	2(4.8)	0(0.0)
3-10 times	3(7.1)	0(0.0)
11 or more times	14(33.3)	0(0.0)
Unknown/No answer	6(14.3)	0(0.0)
Wilcoxin Test:		

aggression is striking. For example, fully 64 percent of the abuse group had been insulted or sworn at 11 or more times in the preceding year. In 35 percent of the cases, relatives had done or said something to spite the older person 11 or more times, and 33 percent had been threatened that frequently. From these data we can conclude that the abuse cases are generally more conflict-ridden.

Comparison of Caseworker and Elder Self-Report

Both common sense and empirical research indicate that people tend to under-report incidents of family violence. Abusive actions such as those included in the CTS are heavily stigmatized, and family members are frequently embarassed to admit that they have occurred. Such an admission is often perceived by the respondent as a sign of family failure; that is, that the family is abnormal. It was expected that the abused elders would tend to under-report violent incidents, just as other victims of domestic violence do.

It is, of course, impossible to precisely determine the amount of under reporting. However, it is worthwhile to look at discrepancies between the reports of violence given by the abused elders and the Model Project case workers. Since it was unrealistic to expect the case workers to be able to estimate the frequency with which a conflict tactic had been used in the preceeding year, they were asked whether the violent act had ever happened since the respondent became elderly. This is compared to the interviewee's response in Table 6.4.

A word is necessary on the statistical procedure used for this analysis: the McNemar test. This is the test of choice, as it is designed for dichotomous variables (2x2 tables) and is appropriate for related samples. In the tables, the response for each elder is matched with the case worker's assessment for that person. Thus, in each individual table in Table 6.4, the responses of the elder appear on the left side, and that of the caseworker across the top. For example, Table 6.4a should be read as follows: there were no cases in which the elder reported that threats had occurred, but the case worker did not; there were 19 cases in which the elder and caseworker agreed threats had occurred; there was one case in which both agreed threats had not occurred; and 12 cases in which the elder denied the occurance of threats, but the case worker reported them. The two-tailed test of significance is significant at the .001 level, indicating that elderly respondents were less likely to report threats.

Interestingly, Table 6.4a is the only item on which a significant amount of disagreement was found between the caseworkers and the abused elders. On every other item, the two reports were not significantly different. More strikingly, in four cases - 6.4b, 6.4c, 6.4g and 6.4i - the the significance level is 1.000, showing especially strong agreement. This is a very encouraging finding for a number of reasons. First, from the standpoint of this study, it confirms that the abuse reported by the elders did in fact occur,
and that the abuse sample was really maltreated. Second, it indicates that the elder abuse workers were well-attuned to the dynamics of the

TABLE 6.4 COMPARISON OF ELDER AND CASEWORKER (cont.)

f. Ever Kicked, Bit, Hit with Fist

Caseworker's Assessment

Elder's Assessment

	No	Yes
Yes	6	13
No	12	2

p=.289

g. Ever Hit or Tried to Hit Other with Something

Caseworker's Assessment

Elder's Assessment

	No	Yes
Yes	6	4
No	18	5

p=1.000

h. Ever Beat Up Other

Caseworker's Assessment

Elder's Assessment

	No	Yes
Yes	1	6
No	20	4

p=.375

i. Ever Threatened with Knife or Gun

Caseworker's Assessment

Elder's Assessment

	Yes	No
Yes	3	2
No	23	3

p=1.000

j. Ever Used Knife or Gun

All values for this variable were "no", so a 2x2 table could not be constructed. This indicates complete agreement.

TABLE 6.4 COMPARISON OF ELDER AND CASEWORKER*

a. Ever Threatened to Hit or Throw Something at Other

Case Worker's Assessment

Elder's Assessment

	No	Yes
Yes	0	19
No	1	12

p=.001

b. Ever Threw, Smashed, Hit or Kicked Something

Case Worker's Assessment

Elder's Assessment

	No.	Yes
Yes	7	12
No	3	6

p=1.000

c. Ever Threw Something at Other

Caseworker's Assessment

Elder Assessment

	No	Yes
Yes	7	12
No	3	6

p=1.000

d. Ever Pushed, Grabbed, Shoved Others

Caseworker's Assessment

Elder's Assessment

	No	Yes
Yes	2	27
No	3	4

p=.688

e. Ever Slapped Other

Caseworker's Assessment

Elder's Assessment

	No	Yes
Yes	9	12
No	8	4

p=.267

*Total number of cases mav not eoual 42 due to missing data.

case, and had obtained a reliable estimate of the studies of elder abuse that had relied on professional assessments of the incidence of abuse (which, as noted earlier, many have done). If the findings discussed here are supported elsewhere, it may be that caseworker's assessments of violence closely mirror those of the victims themselves.

Summary

Three separate analyses were carried out in this section, all of which relate to violent behavior in the abuse sample. It was found that serious violence was extensive in the abuse group, and frequently involved a number of incidents in the year previous to the interview. Respondents were most likely to have been pushed, shoved, or grabbed; slapped; kicked, bit or hit with a fist; or to have had something thrown at them. They were less likely to have been hit with something; to have been beaten up; or to have been threatened or assaulted with a knife or gun. The elderly respondents were very unlikely, by their own report, to have been violent towards the abuser.

Next, the abuse and non-abuse groups were compared on verbal aggression. It was possible that the non-abuse cases experience as much conflict, but resolve it in verbal ways, rather than in violence. In fact, this was not the case: the control group reported much less verbal conflict than did the abuse group. This indicates that families in which physical abuse occurs engage in more of both types of conflict tactics, rather than substituting one for the other. The qualitative data supports this: the abusive families show signs of being generally conflict-ridden.

Finally, the data were analyzed to determine whether differences existed between the abuse victims' report of the violence that had occurred, and that of the caseworkers. Surprisingly, only one significant difference was found. In this case, at least, caseworkers assessments closely match that of the elderly themselves.

D. Intraindividual Dynamics

> "Why do I stay with her? I'd like to see her happy. I feel if you had a kid with leukemia, you wouldn't turn your back. Why should it be different with emotional problems?"

The first hypothesis to be examined is that which attributes abusive behavior to the psychological or emotional problems of the abuser. While many family violence researchers have abandoned this hypothesis, popular opinion generally has it that abusers are "sick" or "abnormal." In this section, the abuse and non-abuse groups are compared on some indicators of psychopathology on the part of the abuser. It should be noted that only a few variables relating to this hypothesis were included in the survey of elderly respondents. As discussed earlier, the original intent was to interview 30 abusers and comparisons. In that interview, the Langner Scale (1962) which is a screening scale for psychiatric symptoms was used. With this scale and other information about the abuser, the plan was intended to establish whether the abusers were more psychologically disturbed. For reasons noted above, however, only a small sample of abusers was obtained, and therefore this analysis was relegated to a sub-study. In this section, the data from interviews with the elderly respondents will be presented Two areas are addressed: psychological problems and substance abuse.

Psychological Problems

Two items were included on the questionnaire for the elderly respondents. First, as part of a list of illness conditions, each respondent was asked: "Does [relative] have any mental or emotional problems?" If the respondent answered affirmatively, she was asked: "How much do these activities interfere with his/her activities: not at all, a little, or a great deal?" As Table 6.5 indicates, the abused elders were much more likely to report psychological or emotional problems on the part of the abuser than were non-abused elders. In fact, only 21 percent of the interviewers reported that no such problems existed. In comparison, over 76 percent of the non-abuse group stated that their relatives had no psychological or emotional difficulties. Another more objective indicator of psycho-emotional illness is psychiatric hospitalization. Table 6.6 presents data that show the relatives of abused elderly to be considerably more likely to have been placed in a psychiatric hospital or unit.

Substance Abuse

It was determined during the design of the questionnaire that questions regarding substance abuse would not be asked directly of the elderly respondents. The Model Project staff in particular felt that this was a very sensitive area for the clients, and one in which honest responses would be difficult to obtain.* Therefore, the Model Project caseworkers and EHC case managers were asked about alcohol or drug abuse in the relative. Most of these caseworkers knew the families sufficiently well to respond to the questions. "To the best of your knowledge, is [relative] an alcoholic?" and "To the best of your knowledge, is [relative] a drug abuser?" As Table 6.6 indicates, the abusers were significantly more likely to be alcoholics than the controls, but neither group was likely to abuse drugs.

Qualitative Data

The qualitative components of the interviews indicate that respondents frequently attributed the abuse they suffered to pathological traits in the abuser. Reviewing the comments, it was found that many of the interviewees directly linked the maltreatment to psychosis, "nerves," alcoholism, or other of the abuser's psychological problems. Here, as examples, are some of the explanations offered by abused elders taken from my notes on the interviews:

---

*In retrospect, the respondents were quite willing to discuss the abuser's substance abuse problems. Such items should be included in a future study.

TABLE 6.5 ELDERLY RESPONDENTS' REPORT OF ABUSERS' MENTAL OR EMOTIONAL PROBLEMS

	Abuse Group	Non-Abuse Group
	# %	# %
No problem	9(21.4)	32(76.2)
Has problem, but does not	1(2.4)	0
interfere with activities	1(2.4)	7(16.7)
Has problem, interferes a little	1(2.4)	7(16.7)
Has problem, interferes a great deal	31(73.8)	3(7.1)

Wilcoxon: p=.000

TABLE 6.6 ABUSER HAS HAD PSYCHIATRIC HOSPITALIZATION/SUBSTANCE ABUSE PROBLEMS

	Abuse Group	Non-Abuse Group
	# %	# %
a) Psychiatric hospitalization		
Yes	15(37.5)	2(5.0)
No	25(62.5)	38(95.0)
p=.002		
b) Caseworker's assessment of whether abuser is alcoholic		
Alcoholic	18(56.3)	3(9.4)
Non-alcoholic	14(43.8)	29(90.6)
p=.001		
c) Caseworker's assessment of whether abuser is drug abuser		
Drug abuser	2(5.7)	0
Non-drug abuser	30(94.3)	32(100.)
p=.500		

--Daughter had breakdown five years ago. About a year or two after, began to be violent towards mother.

--Daughter has always been a "little off." She never minded "and way always in trouble." She was "different."

--"I miss my son. But when he's on drugs, he's impossible."

--Son began to drink again early last summer. He failed to care for his mother, and began to get violent when drunk.

--Daughter had psychotic breakdown. Abuse in this case not long-standing, but result of breakdown.

--"My husband gets mean and uncommunicative, especially when he drinks."

--"My son was in a home for disturbed children for 13 years. He would lie and steal; he was bad from the beginning. He's developmentally disabled."

--Husband has Alzheimer's disease, is in wheelchair, and is completely incontinent. He becomes violent toward wife when she tries to care for him.

--"My son began to deteriorate this year. Then he went into a mental hospital. He was much worse after he got out. He started getting violent. He wouldn't let me use the telephone. In January, he read the book Rocky, and started "training" for boxing. He turned the house into what he called a 'boxing camp.' He kept the drapes closed and the doors locked. I said 'You've got to get out of this.' He said, 'You've got to be strong like Rocky.' Then he hit me in the back. He says, 'How about if we fight it out now? How about if I bash your head in?'"

These examples have been given to show how persuasive an explanation individual psychopathology appears to be, at least from the victim's accounts. In at least half the cases, the victims directly attributed abuse to character traits in the perpetrator. Sometimes they blamed themselves ("I raised him wrong"). In other instances, they cited an act of God: One woman reported that her son became abusive after a serious fall that caused brain damage. Some blamed a stroke, or Alzheimers' disease, while others cited alcohol abuse. In general, when asked "Why does he/she act this way towards you?" respondents were most likely to blame some flaw in the abusers' personality.

Discussion

As noted earlier, a detailed exploration of intraindividual dynamics was not the goal of this project. Based on the limited evidence presented above, however, mention should be made of a few important points.

1) Abused elders were significantly more likely to report that the abuser had psychological or emotional problems than were the control elders. Further, they were more frequently able to cite concrete evidence of emotional disturbance: psychiatric hospitalization.

2) Elder abusers were much more likely to be identified as alcoholics by their case workers than were the controls.

3) In qualitative interviews, the abused elderly frequently cited mental and emotional problems such as developmental disability, psychosis, dementia, and alcoholism as reasons for the relative's abusive behavior.

The question arises: Where do these findings point in our attempt to identify causes of elder abuse? Certainly, these data cannot stand without further support and elaboration. Nothing here has been done to uncover what particular forms of emotional disturbance might precipitate abuse, nor to shed light on the specific way in which alcohol abuse can lead to domestic violence against the elderly. In an exploratory study, focusing on this area would have been inappropriate. However, the data presented here argue for a consideration of individual psychopathology as a primary risk factor in elder abuse. The important difference between the two groups on three out of the four quantitative elements, coupled with the victims' own perceptions, strongly suggest that elder abusers may be especially troubled individuals.

At present, it is not clear why elder abusers would differ from perpetrators of other forms of family violence, who have not been consistently found to be more mentally or emotionally impaired. One possible possible theoretical explanation which was mentioned in Chapter Two might be the difference which exists in the degree of normative prohibition against various types of family violence. Straus, et al. (1980) found a great deal of popular approval for punishing children, and even a surprizingly high approval rate for spousal violence. Striking an elderly person, and in particular a father or mother it a much more deviant act and therefore a stronger normative violation than either child or spouse abuse. One might thus expect a greater degree of psychopathology on the part of elder abusers, as they engage in a more deviant behavior than others.

Such an assertion will, of course, need to be borne out by further research. The findings shown above, however tentative, clearly argue for additional exploration of the role of the abuser's mental and emotional problems in maltreatment of the elderly. This need not have the overtone of labeling the perpetrators as "villains." It may mean simply, for example, that caregiving responsibility has been placed in the wrong hands. It is to be hoped that future studies will illuminate this area to a greater degree.

E. Intergenerational Transmission of Violent Behavior

"We were close when she was a child. We idolized the ground she walked on."

I didn't have to punish. I never hit him."

Studies of child maltreatment, as Gelles and Straus (1979b) report, have shown that individuals who have been abused as children are more likely than others to become child abusers. Similarly, persons who observe violence between their parents have been found to be more likely perpetrators of child abuse. In general, many studies have found links between violence experienced as a child and a tendency to engage in domestic violence in later life. This connection has usually been explained in terms of social learning theory: children learn in the home that violence is an acceptable method of handling conflict. The question to be addressed in this section is whether a "cycle of violence" exists in cases of elder abuse. That is, are elder abusers more likely to have experienced high rates of violence as children, or, more broadly, to have experienced major problems in their childhood?

As with the previous hypothesis (intraindividual dynamics), only a few variables were included on this issue in the survey, in order to explore it in a preliminary fashion. It must be noted that in only one case did a respondent specifically describe her child as the victim of "abus[illegible]n that case, this maltreatment occurred at the hands of the intervi[illegible]s first husband. However, additional data shed some light on the issue of intergenerational transmission.

First, respondents were asked, "What was your relationship with [child] like when he/she was a child and teenager." The responses were written down, and were coded as either "good" or "problems." As Table 6.7 shows, abuse victims were significantly more likely to report that their relationships with the perpetrators were troubled when the latter were children. Respondents were then asked another open-ended question: "How did you usually tend to punish [child] when he/she was a child and teenager?" Responses were again recorded, and coded as "physical mentioned" and "physical not mentioned." The results were surprizing: only one member of each group spontaneously mentioned using physical punishment (Table 6.7). Interviewees were then asked how frequently, in the year in which it happened most, they had used physical punishment. No significant difference was found. The item on punishment by the respondent's spouses was similar (Table 6.8).

The qualitative data from the interviews does not, on the whole, shed much additional light on this issue. Even in the six in-depth interviews, the abuser's childhood was generally described as "good" or "pretty happy." One unexpected finding did surface, however, in the review of the qualitative data: three of the daughters had been victims of abuse, not as a child, but as a spouse. All three had alcoholic husbands who were physically violent towards them. Upon the break-up of

TABLE 6.7 ELDERLY RESPONDENT'S REPORTS

	Abuse Group	Non-Abuse Group
	# %	# %
a) Relationship with abuser when child and teeager*		
Good	13(56.5)	21(91.3)
Problems	10(43.5)	2(8.7)
p=.021		
b) How usually punished children?		
Physical punishment mentioned	1(4.3)	1(4.3)
Physical punishment not mentioned	22(95.6)	22(95.6)
p=1.000		

* Total N is smaller because these questions were only asked in cases where the abuser was respondent's child.

TABLE 6.8 FREQUENCY OF PHYSICAL PUNISHMENT IN YEAR IT HAPPENED MOST

	Abuse Group	Non-Abuse Group
	# %	# %
a) Frequency - Respondent		
Never	10(23.8)	12(28.6)
Once	1(2.4)	3(7.1)
Twice	1(2.4)	6(14.3)
3-5 times	3(7.1)	1(2.4)
6-10 times	3(7.1)	0
11-20 times	1(2.4)	0
20+ times	0	
Missing/not applicable	23(54.8)	20(47.7)
Wilcoxon: p=.753		
b) Frequency - Respondent's Spouse		
Never	6(14.3)	18(42.9)
Once	1(2.4)	2(4.8)
Twice	1(2.4)	1(2.4)
3-5 times	5(11.9)	2(4.8)
6-10 times	1(2.4)	0
11-20 times	1(2.4)	0
20+ times	1(2.4)	0
Missing/not applicable	26(619)	19(45.2)
Wilcoxon: p=.107		

those relationships, all moved in with their elderly mothers, towards whom they then proceeded to engage in abusive behavior. Although extremely speculative, perhaps battered women who "go home to mother" are more likely to be abusive. This is a possible hypothesis for future research.

Discussion

While the data presented here are too limited to be considered definitive, they do not generally support the notion that children who abuse elderly parents were themselves victims of abuse. The abuse victims reported that they rarely used physical punishment; and no difference was found between cases and controls on this issue. While the spouses of victims appeared to punished more frequently than the controls, the difference is not significant. Finally, the qualitative interview data show only one reference to a perpetrator who was a victim of child abuse.

Based on these findings, it appears that this hypothesis may not be a particularly promising one, and that stronger explanations of why elder abuse occurs can be identified. It is also possible that the survey format employed in the present study is not the ideal one to obtain information regarding punishment and abuse of children. In fact, many of the respondents were uncomfortable with the questions, and brushed over them quickly. A future study could focus on this issue, and conduct in-depth interviews with victims regarding possible abuse of their children. Alternatively, interviews could be conducted with the abusers regarding their child and teenage years. It appears that an atmosphere of real trust would needed before the respondents would discuss abusive behavior towards their children; this could more likely be established in an open-ended, in-depth interview.

F. Dependency, Exchange, and Abuse

> "Me? I didn't depend on him! I'd ask him for something, and he'd say he couldn't it right then. He wasn't working the three years he lived with me. He didn't have any other place to go. I wouldn't see him out in the cold. He lived in the bars, and I took care of him. I gave him lots of money. I gave him $1,200 in the last few months!"

> "She is so dependent on me. You know what? Sometimes I put fear in her. I tell her: 'I will not be here forever!' She gets so afraid. that's when she hits me."

Perhaps the most important findings of this study relate to the dependency hypotheses presented on page 200. It is worthwhile here to briefly recapitulate the discussion of this issue. Many researchers on elder abuse have postulated that the dependency of the elderly person causes stress for the abuser, who responds with physical violence. Based on this notion, it would be expected that abused elders to be more physically impaired and more dependent on their relative than the control group. On page 200 an alternative hypothesis based on exchange theory was proposed: abuse can be attributed in many cases to a lack of power on the part of the abuser. Rather than seeing abuse as resulting from frustration on the part of a caregiver, it is viewed in this alternative hypothesis as the result of anger and frustration at occupying a dependent position.

It is the purpose of this section to examine in detail the relationship between dependency and physical abuse of the elderly. Because of the importance of this particular issue, and the evidence from previous studies that it may hold a key to understanding domestic violence against the aged, considerably more data are analyzed here than in other chapters. The quantitative elements cover three basic areas crucial to understanding the association between dependency and abuse. First, there is the question of whether the elderly are more seriously ill or impaired than the controls. Are abused elders, as some have asserted, more likely to have diminished functional capabilities? Second, beyond general impairment, are abused elders specifically more dependent on the abusers than are the controls on the comparison relatives? Third, the reverse of this configuration is examined: are the abusers more dependent on their victims than in the controls? Finally the qualitative data are employed to identify different types of dependency relationships, and to better understand the reasons why victims remain in battering relationships.

Physical Impairment and Functional Dependency

The first issue to be examined is whether abused elderly are in fact more physically impaired and in poorer health. It has been assumed that these characteristics would make the elders more dependent on their kin, and thus cause stress in the relationship. This, in turn, is held to lead to abuse. Alternatively, it may be the case that the elderly are not in poorer health and diminished diminished functional status. Such a finding would lend support to the alternative hypothesis that dynamics other than increased dependency place the victim at risk.

The first measure employed to test this hypothesis is the inventory of illnesses from the Older Americans Resources and Services (OARS) instrument. OARS is a multidimensional assessment questionnaire that measures the functional status of individuals and also classifies them into groups according to their status. The instrument examines five areas of functioning: physical health, mental health, economic resources, social resources, and ability to perform activities of daily living. The reliability, content validity, and consensual validity of OARS have been firmly established (see Duke University Center for the Study of Aging and Human Development, 1978, especially pp. 6-7, for further discussion). It has been employed by a host of researchers and clinicians for community surveys and patient assessment.

Table 6.9 compares the abuse and non-abuse groups on 24 illnesses. It is important to note in 23 out of 24 areas, no significant dif-

TABLE 6.9 CHRONIC CONDITIONS: DEGREE TO WHICH THEY INTERFERE WITH ACTIVITIES

	Abuse Group	Non-Abuse Group
	# %	# %
a) Arthritis		
Does not have condition	12(28.6)	9(21.4)
Interferes not at all	6(14.3)	1(2.4)
Interferes a little	12(28.6)	13(31.0)
Interferes a great deal	12(28.6)	19(45.2)
Wilcoxon: p=.118		
b) Glaucoma		
Does not have condition	34(81.0)	40(95.2)
Interferes not at all	1(2.4)	0
Interferes a little	4(9.5)	2(4.8)
Interferes a great deal	3(7.1)	0
Wilcoxon: p=.042		
c) Emphysema or Chronic Bronchitis		
Does not have condition	29(69.0)	36(85.7)
Interferes not at all	4(9.5)	1(2.4)
Interferes a little	3(7.1)	3(7.1)
Interferes a great deal	6(14.3)	2(4.8)
Wilcoxon: p=.096		
d) Tuberculosis		
Does not have condition	41(97.6)	42(100.)
Interferes not at all	1(2.4)	0
Interferes a little	0	0
Interferes a great deal	0	0
Wilcoxon: p=.317		
d) High Blood Pressure		
Does not have condition	26(61.9)	18(42.9)
Interferes not at all	1(2.4)	16(38.1)
Interferes a little	7(16.7)	5(11.9)
Interferes a great deal	8(19.0)	3(7.1)
Wilcoxon: p=.325		

TABLE 6.9 CHRONIC CONDITIONS: DEGREE TO WHICH THEY INTERFERE WITH ACTIVITIES (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
f) Circulation problems		
Does not have condition	24(57.1)	24(57.1)
Interferes not at all	4(9.5)	1(2.4)
Interferes a little	7(16.7)	9(21.4)
Interferes a great deal	7(16.7)	8(19.0)
Wilcoxon: p=.616		
g) Diabetes		
Does not have condition	37(88.1)	35(83.3)
Interferes not at all	1(2.4)	4(9.5)
Interferes a little	3(7.1)	2(4.8)
Interferes a great deal	1(2.4	1(2.4)
Wilcoxon: p=.894		
h) Ulcers		
Does not have condition	38(90.5)	39(92.9)
Interferes not at all	3(7.1)	0
Interferes a little	1(2.4)	2(4.8)
Interferes a great deal	0	1(2.4)
Wilcoxon: p=.612		
i) Other stomach disorders		
Does not have condition	35(83.3)	36(95.7)
Interferes not at all	1(2.4)	0
Interferes a little	5(11.9)	5(11.9)
Interferes a great deal	1(2.4)	1(2.4)
Wilcoxon: p=.965		
j) Liver Disease		
Does not have condition	41(97.6)	42(100.)
Interferes not at all	1(2.4)	0
Interferes a little	0	0
Interferes a great deal	0	0
Wilcoxon: p .317		

TABLE 6.9 CHRONIC CONDITIONS: DEGREE TO WHICH THEY INTERFERE WITH ACTIVITIES (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
k) Urinary Tract or Prostate Problem		
Does not have condition	37(88.1)	38(90.5)
Interferes not at all	3(7.1)	0
Interferes a little	2(4.8)	2(4.8)
Interferes a great deal	0	2(4.8)
Wilcoxon: p=.515		
l) Cancer or Leukemia		
Does not have condition	41(97.6)	39(92.9)
Interferes not at all	1(2.4)	0
Interferes a little	0	2(4.8)
Interferes a great deal	0	1(2.4)
Wilcoxon: p=.144		
m) Anemia		
Does not have condition	37(88.1)	40(95.2)
Interferes not at all	3(7.1)	1(2.4)
Interferes a little	2(4.8)	1(2.4)
Interferes a great deal	0	0
Wilcoxon: p=.345		
n) Stroke		
Does not have condition	37(88.1)	39(90.5)
Interferes not at all	0	0
Interferes a little	1(2.4)	2(4.8)
Interferes a great deal	4(9.5)	2(4.8)
Wilcoxon: p=.447		
o) Parkinson's Disease		
Does not have condition	41(97.6)	42(100.)
Interferes not at all	1(2.4)	0
Interferes a little	0	0
Interferes a great deal	0	0
Wilcoxon: p=.317		

TABLE 6.9 CHRONIC CONDITIONS: DEGREE TO WHICH THEY INTERFERE WITH ACTIVITIES (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
p) Epilepsy		
Does not have condition	39(92.9)	41(97.6)
Interferes not at all	2(4.8)	1(2.4)
Interferes a little	1(2.4)	0
Interferes a great deal	0	0
Wilcoxon: P=.273		
q) Cerebral Palsy		
Does not have condition	41(97.6)	42(100.)
Interferes not at all	1(2.4)	0
Interferes a little	0	0
Interferes a great deal	0	0
Wilcoxon: p=.317		
r) Multiple Sclerosis		
Does not have condition	38(90.5)	42(100.)
Interferes not at all	1(2.4)	0
Interferes a little	0	0
Interferes a great deal	3(7.1)	0
Wilcoxon: p=.680		
s) Multiple Dystrophy		
Does not have condition	41(97.6)	42(100.)
Interferes not at all	1(2.4)	0
Interferes a little	0	0
Interferes a great deal	0	0
Wilcoxon: p=.317		
t) Thyroid or glandular problem		
Does not have condition	39(92.9)	40(90.5)
Interferes not at all	3(7.1)	1(2.4)
Interferes a little	0	1(2.4)
Interferes a great deal	0	0
WIlcoxon: p=1.000		

TABLE 6.9 CHRONIC CONDITIONS: DEGREE TO WHICH THEY INTERFERE WITH ACTIVITIES (contl)

	Abuse Group	Non-Abuse Group
	# %	# %
u) Skin Disorders or Sores		
Does not have condition	38(90.5)	37(88.1)
Interferes not at all	0	1(2.4)
Interferes a little	3(7.1)	1(2.4)
Interferes a great deal	1(2.4)	3(7.1)
Wilcoxon: p=.594		
v) Speech Impediment		
Does not have condition	39(92.9)	42(100.)
Interferes not at all	2(4.8)	0
Interferes a little	1(2.4)	0
Interferes a great deal	0	0
Wilcoxon: p=.109		
w) Mental or emotional problems		
Does not have condition	26(61.9)	30(71.4)
Interferes not at all	0	0
Interferes a little	6(14.3)	9(21.4)
Interferes a great deal	10(23.2)	3(7.1)
Wilcoxon: p=.638		
x) Other problems		
Does not have condition	21(50.0)	16(39.1)
Interferes not at all	2(4.8)	2(4.8)
Interferes a little	6(14.3)	6(14.3)
Interferes a great deal	13(31.0)	18(42.9)
Wilcoxon: p=.638		

ferences were found between cases and controls. The abuse group had somewhat more glaucoma, but the magnitude of the difference is not great. To further explore this issue, an index was constructed from the 24 illnesses. The coding was as follows: Does not have condition = 0; interferes not at all = 1; interferes a little = 2; interferes a great deal = 3. The scores for each individual were added up, and a paired t-test was performed. As Table 6.10 shows, no significant differences were found between cases and controls on this illness scale. It can be concluded that the abused elders were no more likely to be seriously ill than the controls. This is further supported by three other indicators. The groups did not significantly differ in whether the person was hospitalized in the past year (although, as the table shows, the controls were hospitalized more frequently) (Table 6.10). Similarly, the abuse group was not more likely to report a decline in health status over the past five years or the past one year (Table 6.11).

Much research has shown, however, that diagnostic condition is not as good an indicator of the vulnerability of the elderly as is functional impairment. That is, to what extent is the individual unable to carry out basic functions essential to daily living? Such functions have been categorized by some researchers as personal. Activities of Daily Living, or "ADLs", (bathing, dressing, ambulation, etc.), and Instrumental Activities of Daily Living, or "IADLs" (food shopping, cooking, cleaning, etc.). Many instruments exist to assess functional status. For this study, the Index of Functional Vulnerability (IFV) was selected, developed at the Hebrew Rehabilitation Center for the Aged in Boston, Mass. It is based on a clinical assessment of the functional limitations of a large sample of elder persons in Boston and Cambridge by an interdisciplinary team. This clinical judgement was then replicated using Discriminant Function Analysis, and reduced to a simple 11-point scoring instrument. The IFV in its final version contains measures of mobility, ADL, IADL, and orientation. The items can be examined separately, and as a composite index. The composite IFV classifies persons as "functionally vulnerable," when they have impairments that severely limit their ability to get around or to perform ADLs in the home (Morris, 1982).

The hypothesis that the dependency of the victim leads to abuse would indicate that the abused elders should be more impaired on each item of the IFV, and to be more likely to be classified as functionally vulnerable by the composite index. As Table 6.12 demonstrates, such is not the case; in fact, the reverse appears to hold in some cases. No significant differences were found in the following variables: needing help or having great difficulty with meal preparation (6.12a); being healthy enough to walk up and down stairs without help (6.12d); using a walker (6.12e); or wheelchair (6.12f) at least some of the time to get around; being able to identify the correct year (6.12g); the number of days (6.12j) or feed oneself (6.12l); or in the frequency with which bad health prevents desired activities (6.12k).

From these data, it is clear that abused elderly are not more functionally impaired than the controls in many critical ADLs. Even more

TABLE 6.10 HEALTH INDICATORS

	Abuse Group		Non-Abuse Group
a) Chronic Illness Scale			
Mean	6.3095		6.0952
Standard deviation	6.1190		3.5940
t-value		.017	
Two-tailed proability		.864	
b) Hospitalization in past year	# %		# %
Yes	13(31.0)		22(52.4)
No	29(69.0)		20(47.6)
McNemar: p=.081			

TABLE 6.11 CHANGES IN OVERALL HEALTH

	Abuse Group	Non-Abuse Group
	# %	# %
a) In past five years		
Better	3(7.1)	3(7.1)
Same	12(28.6)	9(21.4)
Worse	27(64.3)	30(71.4)
Wilcoxon: p=.697		
b) In past year		
Better	2(4.8)	4(9.5)
Same	22(52.4)	18(42.9)
Worse	18(42.9)	20(47.6)
Wilcoxon: p=1.000		

TABLE 6.12 ASSESSMENT OF FUNCTIONAL VULNERABILITY

	Abuse Group	Non-Abuse Group
	# %	# %
a) Needs help or has great difficulty with meal preparation		
Yes	14(33.3)	12(28.6)
No	28(66.7)	30(71.4)
McNemar: p=.803		
b) Needs help or has great difficulty in taking out garbage		
Yes	19(45.2)	30(71.4)
No	23(54.8)	12(28.6)
McNemar: p=.029		
c) Health enough to do ordinary work around house		
Yes	26(61.9)	9(21.4)
No	16(38.1)	33(78.6)
McNemar: p=.000		
d) Healthy enouch to walk up and down stairs without help		
Yes	27(69.0)	28(66.7)
No	13(31.0)	14(33.3)
McNemar: p=1.000		
e) Uses walker at least some of the time to get around		
Yes	8(19.0)	11(26.2)
No	34(81.0)	31(73.8)
McNemar: p=.628		

TABLE 6.12 ASSESSMENT OF FUNCTIONAL VULNERABILITY (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
f) Uses wheelchair at least some of the time to get around		
Yes	7(16.7)	2(4.8)
No	33(83.3)	40(95.2)
McNemar: p=.180		
g) Able to identify correct year		
Yes	37(88.1)	40(95.2)
No	5(11.9)	2(4.8)
McNemar: p=.453		
h) In past month, number of days gone out of house or building		
Two days a week or more	24(57.1)	19(45.2)
One day a week or less	18(42.9)	23(54.8)
McNemar: p=.453		
i) Someone helps respondent when goes out		
Yes	18(42.9)	27(69.2)
No	24(57.1)	12(30.8)
McNemar: p=.046		
j) Dresses self without help (including socks and shoes)		
Yes	33(78.6)	35(83.3)
No	9(21.4)	7(16.7)
McNemar: p=.789		

TABLE 6.12 ASSESSMENT OF FUNCTIONAL VULERNABILITY (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
k) Frequency bad health, sickness, or pain prvents activities		
Seldom, sometimes or never	20(47.6)	13(33.3)
Frequently or most of the time	22(52.4)	28(68.7)
McNemar: p=.239		
l) Needs help with feeding (includes cutting food)		
Yes	38(90.5)	40(95.2)
No	4(9.6)	2(4.8)
McNemar: p=.688		
m) Determination of vulnerability based on Index of Fucntional Vulnerability (IFV)		
Vulnerable	23(54.8)	33(78.6)
Not vulnerable	19(45.2)	9(21.4)
McNemar: p=.016		

striking, however, is the finding that in certain areas, the abuse group is significantly less impaired than the control group. The abused individuals were substantially less likely to need help or have great difficulty with taking out garbage (6.12b) and were much more likely to report that they were healthy enough to do ordinary housework (6.12c). Further, significantly fewer members of the abuse group reported needing help to go out of their home (6.12i).

Table 6.12 shows the McNemar test of differences in functional vulnerability. The IFV, as noted, classifies interviewees according to their responses on all the items in Table 6.12 (with the exception of (6.14i). The resulting categories are "vulnerable" (severe functional limitations and at risk of institutional placement) and "not vulnerable" (impaired to a slight degree and not at risk of institutionalization). According to Table 6.12m, the abuse group was significantly less likely to be functionally vulnerable; the controls were more at-risk.

As the IFV does not contain an entirely comprehensive inventory of ADLS, questions were asked relating to four additional areas in which an older person might need assistance (Table 6.13). No significant differences were found in need for help with taking medications (6.13b), bathing (6.13c) or using the telephone (6.13d). The groups did differ in the area of food shopping (6.13a). However, as before, the control group members were more likely to need assistance. The overall picture, then, is quite consistent: the abuse group is not more likely to be impaired in activities of daily living. Further, in a number of areas, they tend to be more independent than the controls.

Dependency of Victim on Abuser

Despite these findings, it could still be argued that while the abuse group is not more impaired in general, they may be more specifically dependent on the abuser. That is, it is necessary to ask: Do abused elders depend more on the abuser (rather than other potential helpers), than do the controls on their comparison relative? To test this, the respondents were asked, for each ADL, if the abuser/comparison ever helped with the activity. If the hypothesis that the dependency of the victim breeds abuse is correct, it would be expected that the abusers would be named as helpers to a greater extent than the control relatives. The data on this question appear in Table 6.14. No significant differences were found in any of the ADLs' thus, the abusers were not more heavily relied upon. An additional measure was included to test the hypothesis. Respondents were asked, as part of a different section, if there was someone who would care for them if they became seriously ill or disabled. Those who answered affirmatively were asked to identify the most likely helper. These responses were then coded as "Helper is abuser/comparison" or "Helper is other." As Table 6.15 shows, the abuse group was much less likely to name the abuser as the person they would be most likely to depend on for help.

TABLE 6.13 NEED FOR HELP WITH OTHER ACTIVITIES OF DAILY LIVING

	Abuse Group	Non-Abuse Group
	# %	# %
a) Food Shopping		
Yes	29(69.0)	39(92.9)
No	13(31.0)	3(7.1)
McNemar: p=.009		
b) Taking medications		
Yes	6(18.2)	7(17.1)
No	27(88.8)	34(82.9)
McNemar: p=1.000		
c) Bathing		
Yes	6(14.3)	10(23.8)
No	36(85.7)	32(76.2)
McNemar: p=.789		
d) Using telephone		
Yes	6(85.4)	1(2.4)
No	35(14.6)	41(97.6)
McNemar: p=.125		

TABLE 6.14 HELP RECEIVED FROM ABUSER/COMPARISON

	Abuse Group	Non-Abuse Group
	# %	# %
a) Abuser/comarison helps prepare meals		
Yes	15(36.6)	15(40.5)
No	26(63.4)	25(59.5)
McNemar: p=.823		
b) Abuser/comparison helps with the garbage		
Yes	19(45.2)	26(63.4)
No	22(52.4)	15(36.6)
McNemar: p=.099		
c) Abuser/comparison helps with ordinary housework		
Yes	17(40.5)	17(40.5)
No	25(59.5)	25(59.5)
McNemar: p=.831		
d) Abuser/comparison helps go up and down stairs		
Yes	4(9.8)	5(12.5)
No	37(90.2)	35(87.5)
McNemar: p=1.000		
e) Abuser/comparison helps go out		
Yes	11(26.2)	15(35.7)
No	30(71.4)	25(59.5)
McNemar: p=.302		
f) Abuser/comparison helps with dressing		
Yes	7(16.7)	7(16.7)
No	35(93.3)	35(83.3)
McNemar: p=1.000		

TABLE 6.14 HELP RECEIVED FROM ABUSER/COMPARISON (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
g) Abuser/Comparison helps with dressing		
Yes	2(4.9)	1(2.4)
No	39(92.7)	41(97.6)
McNemar: p=1.000		
h) Abuser/comparison helps with food shopping		
Yes	21(51.2)	25(59.5)
No	20(48.8)	17(40.5)
McNemar: p=.552		
i) Abuser/comparison helps with medications		
Yes	4(10.8)	3(7.3)
No	33(89.2)	38(92.7)
McNemar: p=.625		
j) Abuser/comparison helps with bathing		
Yes	6(14.3)	3(7.3)
No	36(85.7)	38(92.7)
McNemar: p=.508		

TABLE 6.15 PRIMARY HELPER IS ABUSER/COMPARISON OR OTHER

	Abuse Group	Non-Abuse Group
	# %	# %
Helper is abuser/comparison	10(26.3)	25(62.5)
Helper is other	28(73.7)	15(37.5)
McNemar: p=.004		

One further measure of the dependency of the elder on the abuser/ comparison was employed. In this case, the respondent was directly asked: "People depend on each other for many things. How much do you depend on [abuser/comparison] in each of the following areas?" Respondents were asked to answer "entirely dependent" "somewhat dependent," or "independent," in each of the following areas: housing, cooking or cleaning, household repair, companionship and social activities, financial support, and transportation. As Table 6.16 shows, no significant differences were found in five of the six areas. A difference was found in financial dependency (6.16e), but the non-abuse group was found to rely more on the relative for assistance than the abuse group.

Finally, an index was constructed from these six items. The categories were coded as: independent = 0, somewhat dependent = 1, and entirely dependent = 2. When the two groups are compared using a paired t-test, the results are even more striking: the control group members were significantly more likely to be dependent than were the abused elders (Table 6.17).

When all of the above measures are taken into consideration, the hypothesis that the impairment and dependency of an elderly person leads to abuse must be called seriously into question. None of the data tend even slightly in that direction: either no significant differences were found, or the abuse group was less dependent than the controls. Based on the exchange perspective outlined in a previous chapter, the alternative hypothesis must be explored: that is that the dependency of the abuser on his or her victim is a critical predictor of abuse.

Abuser Dependency

Two measures were employed to assess the extent to which the abuser/ comparisons were dependent on the elderly respondents. The first involved an index identical to that in Table 6.16, with the exception that the questions were reversed. That is, the respondent was asked: "How much does [abuser/ comparison] depend on you in these areas?" Table 6.18 displays the results for these items. The abusers were found to be significantly more dependent on the elder in three areas: housing (6.18a) household repair (6.18c) and financial assistance (6.18e). Differences for transportation approached significance (6.18f). The dependency index (Table 6.19) supports these findings: the abusers scored significantly higher on the index.

A second set of items was also included to further examine imbalanced exchange between abuser and victim. The respondents were asked to imagine that they and their relative had decided to separate and establish separate residences, and that contact between them was totally broken off. They were then told: "I'm going to read you things that could be affected by a break-up like this, and for each one, I'd like you to tell me who you think would be hurt more by it: you, [abuser/comparison], neither of you, or both about the same." The results of these items are extremely interesting (Table 6.20). The

TABLE 6.16 DEPENDENCY OF ELDER ON ABUSER/COMPARISON

	Abuse Group	Non-Abuse Group
	# %	# %
a) Housing		
Independent	31(73.8)	27(64.3)
Somewhat dependent	7(16.7)	8(19.0)
Entirely dependent	4(9.5)	7(16.7)
Wilcoxon: p=.279		
b) Cooking and/or cleaning		
Independent	28(66.7)	24(57.1)
Somewhat dependent	8(19.0)	15(35.7)
Entirely dependent	6(14.3)	3(7.1)
Wilcoxon: p=.909		
c) Houshold repair		
Independent	32(76.2)	29(69.0)
Somewhat dependent	2(4.8)	4(9.5)
Entirely dependent	8(19.0)	9(21.4)
Wilcoxon: p=.687		
d) Companionship		
Independent	26(61.9)	16(38.1)
Somewhat dependent	13(31.0)	25(59.5)
Entirely dependent	3(7.1)	1(2.4)
Wilcoxon: p=.144		
e) Financial Assistance		
Independent	29(69.0)	20(47.6)
Somewhat dependent	12(28.6)	20(47.6)
Entirely dependent	1(2.4)	2(4.8)
Wilcoxon: p=.033		

TABLE 6.16 DEPENDENCY OF ELDER ON ABUSER/COMPARISON (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
f) Transportation		
Independent	31(73.8)	21(50.0)
Somewhat dependent	7(16.7)	15(35.7)
Entirely depdendent	4(9.5)	6(14.3)
Wilcoxon: p=.097		

TABLE 6.17 DEPENDENCY SCALE OF ELDER ON ABUSER/COMPARISON

	Abuser Group		Non-Abuse Group
Mean	2.0750		3.4500
Standard deviation	2.515		2.171
t-value		-2.71	
Two-tailed probability		.010	

TABLE 6.19 DEPENDENCY SCALE OF ABUSER/COMPARISON ON ELDER

	Abuse Group		Non-Abuse Group
Mean	3.6842		2.5560
Standard deviation	2.752		2.424
t=value		2.13	
Two-tailed probability		.040	

TABLE 6.18 DEPENDENCY OF ABUSER/COMPARISON ON ELDER

	Abuse Group	Non-Abuse Group
	# %	# %
a) Housing		
Independent	19(45.2)	29(69.0)
Somewhat dependent	5(11.9)	6(14.3)
Entirely dependent	18(42.9)	7(16.7)
Wilcoxon: p=.002		
b) Cooking or Cleaning		
Independent	20(47.6)	20(47.6)
Somewhat dependent	12(28.6)	14(33.3)
Entirely dependent	10(23.8)	8(19.0)
Wilcoxon: p=.838		
c) Household repairs		
Independent	33(78.6)	40(95.2)
Somewhat dependent	2(4.8)	0
Entirely dependent	7(16.7)	2(4.8)
Wilcoxon: p=.047		
d) Companionship		
Independent	22(52.4)	17(40.3)
Somewhat dependent	14(33.3)	18(42.9)
Entirely dependent	5(11.9)	6(14.3)
Wilcoxon: p=404		
e) Financial assistance		
Independent	15(35.7)	26(61.9)
Somewhat dependent	21(51.0)	14(33.3)
Entirely dependent	6(14.3)	2(4.8)
Wilcoxon: p=.031		
f) Transportation		
Independent	29(69.0)	37(88.1)
Somewhat dependent	10(23.8)	3(7.1)
Entirely dependent	3(7.1)	2(4.8)
Wilcoxon: p=.071		

TABLE 6.20 HURT BY SEPARATION

	Abuse Group	Non-Abuse Group
	# %	# %
a) Hurt by being lonely		
Elder hurt more	8(20.5)	16(39.0)
Both hurt same	7(17.9)	12(29.3)
Abuser/comparison hurt more	14(35.9)	7(17.1)
Neither hurt	10(25.6)	6(14.6)
Chi-square: p=0638		
b) Hurt by having to do household chores		
Elder hurt more	8(20.0)	17(41.5)
Both hurt same	0	5(12.2)
Abuser/comparison hurt more	17(42.5)	15(36.6)
Neither hurt	15(37.5)	4(9.8)
Chi-square: p=.0021		
c) Hurt by not being able to get around as easily		
Elder hurt more	9(22.5)	19(46.3)
Both hurt same	0	4(9.8)
Abuser/comparison hurt more	9(22.5)	7(17.1)
Neither hurt	22(55.0)	11(26.8)
Chi-square: p=.0094		
d) Hurt more financially		
Elder hurt more	11(27.5)	24(58.5)
Both hurt same	3(7.5)	5(12.2)
Abuser/comparison hurt more	21(52.5)	3(7.3)
Neither hurt	5(12.5)	9(22.0)
Chi-square: p=.0002		

TABLE 6.20 HURT BY SEPARATION (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
e) Hurt by loss of friends		
Elder hurt more	0	0
Both hurt same	1(2.5)	4(10.3)
Abuser/comparison hurt more	3(7.5)	0
Neither hurt	36(90.0)	35(89.7)
Chi-square: p=.0906		
f) Hurt by relatives being angry		
Elder hurt more	1(2.5)	2(5.3)
Both hurt same	1(2.5)	9(23.7)
Abuser/comparison hurt more	3(7.5)	3(7.9)
Neither hurt	35(87.5)	24(63.2)
Chi-square: p=.0041		

TABLE 6.21 HAVING ENOUGH MONEY IS A PROBLEM

	Abuse Group	Non-Abuse Group
	# %	# %
Yes	22(52.4)	13(31.0)
No	20(47.6)	29(69.0)
McNemar: p=.066		

abused elders were significantly less likely to identify themselves as hurt the most in the areas of household chores (6.20b), getting around (6.20c), and finances (6.20d). In the first two of those areas, similar percentages believed the abuser/comparison would be hurt more, but the abused elders tended to feel more strongly that neither would be hurt. That is, a sense of mutual independence in household chores and personal mobility was more likely to exist in the abusive families, while the non-abused individuals saw themselves as more dependent on their relative. Neither group reported that either party would be hurt more by disappointed relatives or loss of friends, although the control group tended to say that both would be hurt more on the former issue, rather than neither hurt (6.20e and 6.20f).

The most glaring difference exists in the area of finances. The abused elders viewed their relative as much more likely to be hurt financially as the result of a separation: over half responded in this fashion. This finding is of great importance, especially in conjunction with the data in Table 6.20e, which shows fewer than 36 percent of their victims. Financial dependency on the part of the abuser may be an especially important predictor of violence. This issue will be discussed later in the conclusion to Chapter Ten. In the meantime, the qualitative findings presented below help to support the quantitative data.

Qualitative Data

If anything, the general portrait of abusers as persons with strong dependencies on their victim is even clearer from the qualitative data than in the above discussion. To be sure, the issue of dependency is a complex one, and is likely to be mutual rather than entirely one-sided. While the predominance of cases exhibited abuser dependency on the abused, some relationships were at variance with that model.

After a number of careful readings of the notes from each interviewee, it became possible to categorize the cases according to similarities of the dynamics. This was not done through any rigorous coding scheme. Instead, the cases were classified according to what appeared to be the salient features of the dependency relationship. Three basic areas emerged. The first group included cases in which issues of dependency were unclear or ambiguous. These involved, for example, cases of spouse abuse which had been occurring prior to either spouse's turning 65. The second group consisted of cases in which the dependency of the abused person appears to be related to conflict and violence. The third and largest category involved cases where the abuser is substantially dependent on the abused. Although the number of cases in each category has been noted, this should not be taken as an exact quantitative description of where the cases stand. Some cases were ambiguous, and could arguably have been included in a different category. The point here is to give a general picture of the way dependency relationships are played out in families where an elderly person is physically abused.

Ambiguous cases

In eight cases, the question of dependency did not appear as particularly salient. Issues of imbalanced exchange did not surface to a great degree in the interviews, and did not seem to be important in explaining the maltreatment. For example, the case discussed in an earlier section that involved an elderly woman and her adopted son exhibited relative independence on the part of both persons. The son was employed and paid his mother rent, while the latter self-sufficiently ran the household. The abuse occurred over a homosexual relationship in which the son was engaged. Similarly, in one of the few cases in which the abuser and abused did not live together, the son has attacked his mother at family holiday gatherings, but neither regularly depends on the other. Four of the cases in this category involved long-standing cases of spouse abuse. In each of these relationships, the wives had been abused by their husbands for years prior to turning 60. Although dependency issues certainly appear in these relationships, they did not stand out as particularly important in understanding the abuse pattern. These marriages were described as ones in which conflict and abuse had been habitual for years.

Victim Dependent on Abuser

It is this dependency pattern that has been considered the modal one by a number of previous researchers. In these cases, the respondents' increased impairment had led to increased responsibility on the part of a caretaker, which in turn increased stress in the relationship. The abuse in these cases was thus linked to the increased dependency of the elder. Only seven cases could be classified in this category.

Interestingly, five of these cases involved wives who had become dependent on their husbands. In two cases, the wife had experienced both physical and mental deterioration, and were reported both by the respondent and the Model Project worker to be extremely difficult to care for. One women was bed-bound and required almost constant care from her elderly husband. She frequently insulted him and complained about the care he was giving her. Her husband, in a separate interview, reported that he occasionally struck her when he "couldn't take it anymore." In the other case, the wife wandered from home, refused to stay away from the stove, and was in general hard to care for. Although not so extreme, the abusers in the other three cases seemed to fit the stressed-caregiver pattern. The remaining two cases that were similar involved a mother dependent on her son and daughter-in-law, and a sister dependent on her brother.

To obtain a clearer picture of the stress of caregiving, it will be useful to quote from one of the interviews with an abuser. From the reports of her caseworker, this woman was attempting as best she could to meet the needs of her erratic and very demanding mother. She reported:

Ms. B.: Sometimes I feel like a slave...I do all the cooking and cleaning. My mother wakes up at 6:15. She must use the commode and all that stuff. At 7:00 I have to help her with her stockings, and her brace and everything. Then she sits in the dining room waiting for breakfast. I have to squeeze oranges, I have to cook oatmeal, I have to serve her. I work 24 hours a day for her.

Interviewer: Does she ever thank you for that?

Ms. B.: Never! Never!

Interviewer: And your mother couldn't live on her own?

Ms. B.: No.

Interviewer: It sounds like you'r caught in the middle of things. Do you have any idea of a way out or a solution?

Ms. B.: I think I have to die, that's it. That is the only solution.

Although it is impossible to ascertain whether this respondent actually performed the activities she claimed she did, it is clear that the stress of caregiving was taking its toll on her. She reported pushing and hitting her mother when the strain became too great.

Abuser Dependent on Victim

As the previous subsection shows, in a small number of cases physically abusive relationships involve a dependent elder. However, in a sizeable majority of cases, (27) the qualitative data present a quite different picture. In these cases, the victims are supporting a dependent person, who maltreats them. This point should not be overemphasized, however, for the preceding subsections demonstrate that mutual dependency and that of victim on abuser are sometimes found. However, most of the descriptive data collected for this study confirm the quantitative results: physically abused elders are more likely to be depended upon than dependent.

A few vignettes of some typical cases will help to clarify this point.

- An elderly woman had lived with her son for six months. "He drank all the time. You never know how he was going to come home. He wouldn't work, wouldn't pay rent." She supported him throughout this period.

- The daughter of one victim moved in with her, and has never contributed in any way to her mother's support. "I support her. She has epilepsy and is on disability. She's supposed to give me $50.00 a month but she never does. She even stole a $25.00 gift certificate I won. We haven't gotten along ever. It's only nice when she's not here."

- An elderly couple had both been victims of their son's violent behavior. He is around 30, and had lived on his own for a while before he had a serious accident. He fell three stories while painting a house, fractured his skull, and was in a coma for two weeks. His behavior is erratic, and he shouts at his parents. He baits his father, and forces his mother off the telephone. His disability pension was cut off, and he contributes little or no money to the household. His mother has been injured trying to intervene in physical conflicts between father and son.

- A woman in her early sixties lives with her mildly brain damaged son. "He's violent and abusive. He's slapped me in the face, bruised me, kicked me in the shins. I have gone out to motels at six times in the past 18 months, but I have to stop because last time he wrecked my room." She supports him entirely: "He should help more, but he doesn't. He's a very strong man. He should take out the trash. He should mow the lawn and keep the walk shoveled. He won't help at all." He provides no financial assistance whatsoever.

- The daughter of an elderly women moved in with her following her divorce. The daughter has severe emotional problems and cannot work. "She was a wreck when she came here." The daughter has struck her, and has thrown a pan of scalding water on her. Her mother provides for her in almost everyway. "My daughter never washes the dishes or the floor. I'd like her to go out and get a job. Her being unemployed makes it harder on our relationship, especially because she needs money. I support her entirely financially. I'm pushed to the wall and I have to do this."

An interesting variant in this category were five cases in which wives were abused by severely disabled husbands they were caring for. One case, that of the multiple sclerosis victim with a demented husband, has already been presented. Two more examples are as follows:

- A tiny women, living in an elderly housing project, had had a stable relationship with her husband. He became demented, and needed constant supervision. "He would beat me pretty bad, choke me. He grabbed me and said 'I'll kill you.'"

- An elderly woman is the primary caretaker for her wheelchair-bound husband. He is totally incontinent. In the preceding few months, he had become violent. He rips his diapers off and won't let her change them. He threatens her with his walker, and has hit her when she tries to take care of him.

From these case descriptions, the image of the elder abuser as a usually stable, well-intentioned individual who is brought to violent behavior by the excessive demands of an old person can be questioned. In these examples, the abusers appear as persons with few resources, who are frequently unable to meet their own basic needs. Instead, they are heavily dependent individuals: sometimes children who have been unable to separate from their parents; sometimes disabled or demented spouses. Rather than being powerful in the relationship, they are relatively powerless.

This point leads to an important question: why, if the abused elder frequently holds a good deal of power in the relationship, does he or she not get out of it? That is, why does a victim submit to abuse rather than putting the abuser out? A plausible explanation for this phenomenon can be derived from exchange theory. If it is assumed that people weigh the rewards and costs of any situation, it can also be assumed that either remaining in an abusive relationship provides rewards of some kind, or that leaving the relationship appears to carry too many costs. What, then, might these rewards and costs be? While no definitive data are available that would answer this question, some of the open-ended responses shed light on the issues.

By far the most commonly given reason for staying with an abusive dependent relative was one that stressed the formal relationship, and indicated that no other choice was really available. Such responses included the following:

> "I'm her mother and their isn't anybody else to do these things for her."
>
> "I was brought up to take of your own. Where else is she going to do?"
>
> "He's my husband. He'd do the same for me."
>
> "You can't throw your children out."
>
> Other victims elaborated on the relationship tie by expressing worry over what the relative (most often a child) would do without them.
>
> "We take him back because he don't have no other place to go."
> "I should let him go, but I haven't got the heart to put him out."
>
> "I can't put her out. Where can I put her? I haven't got the heart. She couldn't support herself."
>
> "Why do I let her stay here? I have a hard time taking dogs to the pound, that's the kind of person I am. There's your answer."

A few spouses cited a desire to reciprocate for past kindness.

> "He's my husband. He'd do the same for me."
>
> "I wouldn't leave him because he was a good husband when he was well."

In a few cases, the victim reported that he or she would lose concrete rewards if the abuser were forced to leave. Loneliness was one consequence:

> "He's all I've got in the world."
>
> "I still miss him."
>
> "Having her live here helped, because I'm afraid of crime. It's better not to get the reputation of living alone.

Separation from grandchildren was another fear:

> "If she needs something, I never say no. I feel if I take it from her I take it out of her grandchildren's mouth."

Similarly, one elderly woman was unwilling to put out her daughter-in-law, for fear that she would be kept from the grandchildren:

> "I did with her for my grandchildren's sake. I didn't have the heart to say get out. I just couldn't do it...I'd miss the kids. I'd be worried about the kids. At least I felt that while they were here I could see them...that's my main thing now, my grandchildren.

Interestingly, only one respondent reported fear of retaliation from the abuser as a reason for not breaking off contact with him. This was the man quoted in an earlier chapter, who noted "so as not to make a scene, I let him in. We don't try to be soft on him, it's just that we don't want no trouble...to keep the peace, we let him have a couple of dollars so he'll leave us alone." This man was afraid of physical harm should he defy his son. No other respondent cited fear of harm as a motivation for not separating from the abuser.

Discussion

The findings reported in this chapter have major implications for the study of elder abuse. Since these implications will be discussed later they will not be given in great detail here. However, a few points deserve mention. First, and most important is the following: based on the combined weight of the data presented in this chapter, the hypothesis that the dependency of victim on abuser is the major cause of elder abuse should be rejected. Instead, the hypothesis that the dependency of the abuser leads to abuse was generally supported. Second, the typical abused elder tends to be an older women who is supporting a dependent child, or, to a lesser extent, a disabled spouse. They tend to perceive the exchange relationships in which they are involved as highly inbalanced in the abuser's favor. They feel they are giving much, and receiving little. The quantitative data on dependency presented above tend overwhelmingly to support this picture. When queried as to why they did not separate from the abuser, the victims frequently cited a sense of family obligation.

It has not been possible in this research to precisely specify why being dependent on an older person would lead one to abuse that individual. From the examples given above, it is clear that financial exploitation is a factor: the abuser uses violence to obtain money or goods from the victim. Certainly, the mental and emotional problems many abusers experience may make them less able to resolve differences in a non-violent way. Finally, the theory that a sense of powerlessness in every other area can lead to use of violence would appear to apply here. These issues will be elaborated upon in the final two sections of this chapter.

G. External Stress

There are many issues in the study of stressful life events that remain to be resolved. These include how long the referent period for the reporting of events should be (e.g., six months versus one year) and whether "positive" stressors, such as taking a vacation should be included in a life events scale. If the present research project were one in which the study of stress were the primary issue, it would be important to address such technical problems. In the present case, however, the goal was simply to explore the role of external stress in elder abuse in a preliminary way.

For this reason, a simple measure of stress designed for a survey of elder abuse by researchers at the Family Relations Laboratory at the University of New Hampshire (Finkelhor, 1982) was chosen. They constructed a short list of life events which they contend has two advantages: it uses the household as the level of analysis and it consists of events that are more likely to occur at the end of the family life cycle. Prior to the administration of this scale, a question was asked about chronic financial stress. Respondents were queried: "sometimes financial problems can create stress. Is having enough money ever a problem for you?" No significant difference was found (Table 6.21), although the abuse group reported somewhat more stress on this issue.

The individual components of the life events scale appear in Table 6.22. Significant differences were found in only three items: someone was arrested, someone left the household, and someone joined the household. In each of these cases, the abuse group was more likely to have experienced stress than the control group. This is reflected in Table 6.23, in which positive responses were tallied into one rating for the number of stressful life events in the preceding year. The average num-

TABLE 6.22 STRESSFUL LIFE EVENTS IN THE PAST YEAR

	Abuse Group	Non-Abuse Group
	# %	# %
a) Someone in household died		
Yes	1(2.4)	1(2.4)
No	41(97.6)	41(97.6)
McNemar: p=1.000		
b) Close relative of someone in the household died		
Yes	12(28.6)	4(9.5)
No	30(71.4)	38(90.5)
McNemar: p=.080		
c) Someone in the household has been ill or injured		
Yes	26(61.9)	24(57.1)
No	16(38.1)	18(42.9)
McNemar: p=.823		
d) Someone in the household was divorced		
Yes	1(2.4)	0
No	41(97.6)	42(100.)
McNemar: p=1.000		
e) Someone in the household got married		
Yes	1(2.4)	0
No	41(97.6)	42(100.)
McNemar: p=1.000		
f) Someone was arrested		
Yes	9(21.4)	0
No	33(78.6)	42(100.)
McNemar: p=.004		

TABLE 6.22 STRESSFUL LIFE EVENTS IN THE PAST YEAR (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
g) Someone left the household		
Yes	11(26.2)	2(4.8)
No	31(73.8)	40(95.2)
McNemar: p=.004		
h) Someone joined the household		
Yes	9(21.4)	1(2.4)
No	33(78.6)	41(97.6)
McNemar: p=.020		
i) Someone lost a job		
Yes	6(14.3)	2(4.8)
No	36(85.7)	40(95.2)
McNemar: p=.289		
j) Someone retired		
Yes	1(2.4)	0
No	41(97.6)	42(100.)
McNemar: p=1.000		
k) Household changed residence		
Yes	1(2.4)	1(2.4)
No	41(97.6)	41(97.6)
McNemar: p=1.000		

TABLE 6.23 STRESS SCALE

	Abuse Group	Non-Abuse Group
Mean	1.8571	0.8333
Standard deviation	1.407	.794
t-value	4.45	
Two-tailed probability	.0000	

ber of stressful life events was significantly higher for the abuse group. Unfortunately, the responses to the life events scale are confounded by the abuse situation itself. That is, in the three significant variables, the abuser was the person involved. In most of the incidents involving arrest, the abuser was arrested because of the violence. Similarly, a number of abusers entered and left the household in the same year, because the situation became untenable. If these three questions were dropped, none of the stress items would have been significant.

Thus, it can be concluded that the two groups did not differ in stressful events unrelated to the abuser. The death or illness of household members did not strike the abusive families more frequently, nor did divorce or unemployment. In future studies, the stressful life events scale should be further modified to separate out abuser-related stress from that from external sources. The qualitative data shed very little additional light on this question. Stress was virtually never spontaneously mentioned by the respondents as an explanation for the abuser's behavior. When asked an open-ended question -"What do you find stressful in your life right now?" - half of the respondents cited problems in their relationship with the abuser as the major stressor, rather than other specific events.

Two possible conclusions can follow from this evidence. The first is that stress has not been optimally measured here, and that other indicators would achieve better results. Alternatively, it may be that the hypothesis that external stress increased risk of abuse is not correct, and that no relationship exists. This last explanation is supported to an extent by the material in previous chapters. The perpetrators have been found to have emotional problems, to be alcohol-dependent, and to be involved in long-term dependent relationships with the victim. The abuse appears to be more closely related to this configuration of factors than to the effects of stressful life events.

H. Social Isolation

Social isolation could potentially be a risk factor in elder abuse for two reasons. First, social support has been found to be an important moderator of life stress, and may keep tensions within the family from rising to unmanageable levels in a stressful environment. Second, the presence of interested outsiders can make it more difficult to commit acts of violence against a relative; such individuals may intervene themselves, or contact the police or service agencies. Thus, it is hypothesized that the physically abused elderly will be less likely to have a high degree of social support.

Several measures were employed to test this hypothesis. Respondents were asked how many living sons, daughters, sisters, and brothers they had. According to Table 6.24, the non-abuse group tended to have more sons; the magnitude of the difference, however, is slight. No significant differences were found in the number of other relatives. Respondents were also asked whether the relative lived within a half

TABLE 6.24 NUMBER OF RELATIVES

	Abuse Group		Non-Abuse Group
a) Total sons			
Mean	1.2619		1.7619
Standard deviation	1.308		1.265
t-value		-2.11	
Two-tailed probability		.041	
b) Total daughters			
Mean	1.0238		1.2857
Standard deviation	1.137		1.274
t-value		-1.06	
Two-tailed probability		.298	
c) Total brothers			
Mean	1.3333		.8095
Standard deviation	2.666		1.042
t-value		1.12	
Two-tailed probability		.268	
d) Total sisters			
Mean	1.3095		1.0476
Standard deviation	1.370		1.209
t-value		.88	
Two-tailed probability		.386	
e) Number of relatives who live nearby			
Mean	2.7143		2.7143
Standard deviation	2.288		1.852
t-value		.00	
Two-tailed probability		1.000	
f) Number of relatives who visit or call at least once a week			
Mean	1.1190		1.5952
Standard deviation	1.611		1.483
t-value		-1.42	
Two-tailed probability		.164	

hour's drive or less, and how frequently they had contact with the person (either in person or by telephone). No difference was found in the number of relatives who lived nearby (Table 6.24e), or in the number of relatives who visited once a week or more (6.24f).

A more in-depth look at social support was obtained by using the Social Resources Rating Scale (SRRS), which is part of the OARS instrument. This scale measures the quality and quantity of relationships with family and friends, as well as the availability of assistance should the person require it (i.e. Center for the Study on Aging and Human Development, especially Chap. 21; George, L.K., et al., 1982). The scale contains eight items, which appear in Table 6.25.

No significant differences were found on any of the items. However, it is interesting to note that on every variable, the non-abuse group appears to have more social support. One variable-whether one sees friends and relatives as often as one would like - approaches significance, with the abuse group tending to be more unhappy.

One important feature of these items is that they can be scaled into five indices of social support. Table 6.26 shows results of these scales. Table 6.25 (CONTACT), combines items (a), (b), and (c) in Table 6.26. The variable CONTACT allows the amount of contacts as measured by these three variables to be coded as "few," "adequate," or "extensive." This scale shows a difference between the groups, with the abused clients having significantly less contact.

The second constructed variable, FAMILY contains items (d), (g), and (g) in Table 6.25, which measure satisfaction with contacts. As Table 6.26b demonstrates, the abused elders were significantly more likely to be unsatisfied with their social relationships. The third scale, SEE OTHER, combines the items in CONTACT AND FAMILY into one measure of the extent of and satisfaction with contacts; it too was significant, with the abuse group scoring lower (Table 6.26c).

The fourth variable, HELP, measures the availability of assistance from members of the informal support network. It is constructed from items h and e in Table 6.25. Again, no significant differences were found between the groups. Finally, all the items can be combined into one composite scale (SOCRATE). It is worthwhile to give the definitions of each of the categories that appear in Table 26d.

1. Excellent social resources.
   Social relationships are very satisfying and extensive; at least one person would take care of him(her) indefinitely.

2. Good social resources.
   Social relationships are fairly satisfying and adequate and at least one person would take care of him(her) indefinitely.
   OR
   Social relationships are very satisfying and extensive; and only short term help is available.

TABLE 6.25 SOCIAL RESOURCES

	Abuse Group	Non-Abuse Group
	# %	# %
a) How many people do you know well enough to visit in their homes?		
None	2(4.8)	2(4.8)
1-2	10(23.8)	6(14.3)
3-4	12(28.6)	10(23.8)
5 or more	18(42.9)	24(57.1)
Wilcoxon: p=.2424		
b) About how many times did you talk to someone.. friends, relatives, others.. on the telephone in the past week?		
Not at all	4(9.5)	1(2.4)
Once	3(7.1)	3(7.1)
2-6 times	11(26.2)	9(21.4)
Once a day or more	24(57.1)	29(69.0)
Wilcoxon: p=.216		
c) About how many times in the past week have you spent some time with someone who does not live with you?		
Not at all	8(19.0)	5(11.9)
Once	6(14.3)	3(7.1)
2-6 times	17(40.5)	27(64.3)
Once a day or more	11(26.2)	7(16.9)
Wilcoxon: p=.456		
d) Do you have someone you can trust and confide in?		
Yes	35(83.3)	39(92.9)
No	7(16.7)	3(7.1)
McNemar: p=.289		

TABLE 6.25 SOCIAL RESOURCES (cont.)

	Abuse Group	Non-Abuse Group
	# %	# %
e) How often would you say you feel lonely?		
Quite often	16(39.0)	8(19.0
Sometimes	12(29.3)	15(35.7)
Never	13(31.7)	19(45.2)
Wilcoxon: p=.090		
f) Do you see your friends and relatives as often as you would like to, or are you seomwhat unhappy about how little you see them?		
As often as wants	13(31.7)	23(54.8)
Somewhat unhappy	28(68.3)	19(45.2)
McNemar: p=.289		
g) Is there someone who would give you any help at all if you became sick or disabled?		
Yes	37(88.1)	37(90.2)
No	5(11.9)	4(9.8)
McNemar: p=1.000		
h) Is there someone who would help you indefinitely, or for a short time or only now and then?		
Indefinitely	14(36.8)	18(48.6)
Short time	12(31.6)	9(24.3)
Now and then	12(31.6)	10(27.0)
Wilcoxon: p=.386		

TABLE 6.26 COMPONENTS OF THE SOCIAL RESOURCES RATING SCALE

	Abuse Group	Non-Abuse Group
	# %	# %
a) CONTACT: Extent of contact with others		
Few	15(35.7)	7(16.7)
Adequate	5(11.9)	4(9.5)
Extensive	22(52.4)	31(73.8)
Wilcoxon: p=.024		
b) FAMILY: Satisfaction with contacts		
Unsatisfactory	16(39.0)	8(19.0)
Fairly satisfactory	18(42.9)	18(42.9)
Very satisfactory	7(16.7)	16(38.1)
Wilcoxon: p=.019		
c) SEE OTHER: Extent of and satisfaction with contcts		
Low	20(48.8)	10(23.8)
Medium	16(38.1)	17(40.5)
High	6(11.9)	15(35.7)
Wilcoxon: p=.007		
d) HELP: Availability of help		
None	4(9.5)	5(11.9)
Occasional	12(28.6)	10(23.8)
Short-term	12(28.6)	9(21.4)
Long-term	14(33.3)	18(42.9)
Wilcoxon: p=.593		
e) SOCRATE: Overall Social Resources Rating		
Excellent	3(7.1)	7(16.7)
Good	7(16.7)	11(26.2)
Mild impairment	9(21.4)	6(14.3)
Moderate impairment	11(26.2)	11(26.2)
Severe impairment	9(21.4)	4(9.5)
Total impairment	2(4.8)	3(7.1)
Wilcoxon: p=.105		

3. Mildly socially impaired.
   Social relationships are unsatisfactory, of poor quality, few; but at least one person would take care of him(her) indefinitely.
   OR
   Social relationships are fairly satisfactory, adequate; and only short term help is available.

4. Moderately socially impaired.
   Social relationships are unsatisfactory, of poor quality, few; and only short term care is available.
   OR
   Social relationships are at least adequate or satisfactory; but help would only be available now and then.

5. Severely socially impaired.
   Social relationships are unsatisfactory, of poor quality, few; and help would only be available now and then.
   OR
   Social relationships are at least satisfactory or adequate; but help is not even available now and then.

6. Totally socially impaired.
   Social relationships are unsatisfactory, of poor quality, few; and help is not even available now and then (L.K. George, et al., 1982).

No significant differences were found between abused and non-abused elders on the overall Social Resources Rating Scale. One additional item (not part of the scale) asked about organizational memberships. The results approached significance, with the abused elders less likely to belong to organizations (Table 6.27).

Taking all of the above into consideration, the evidence regarding social support is fairly clear. The abused elders to have fewer overall contacts and score significantly lower on their subjective evaluation of their social situation. They are not less likely, however, to have someone to help them if they required it. It may be that the critical issue is the amount of involvement of outsiders in the home: the greater this is, the less easily a relative can be abusive without incurring the costs of negative sanctions from others. Such a finding would certainly be consistent with research on other forms of family violence (see Chapter Two).

One additional point needs mention here. Being in an abusive relationship may not only be an effect of lack of social contact; in fact, the causal path may be in the opposite direction. That is, the abuser may prevent or inhibit outside social contact through threatening behavior, or the conflict in the situation may make others uncomfortable

TABLE 6.27 BELONGS TO CHURCH, CLUB, OTHER ORGANIZATIONS

	Abuse Group	Non-Abuse Group
	# %	# %
Yes	26(61.9)	35(83.3)
No	16(38.1)	7(16.7)

McNemar: p=.052

TABLE 6.28 ABUSER/COMPARISON AFFECTS CONTACT NEGATIVELY

	Abuse Group	Non-Abuse Group
	# %	# %
Yes	21(65.6)	4(10.5)
No	11(34.4)	34(89.5)

McNemar: p=.000

and therefore less likely to visit. In fact, as Table 6.28 shows, the abused elders were much more likely to report that their relationship with the abuser had a negative impact on their contacts with others.

This aspect of the abuse situation comes through strongly in the qualitative data. No respondent cited social isolation as a possible cause of abuse. Many, however, did cite the abuser as a major factor in the diminished social contact. In some cases, this took the form of directly preventing interaction with friends and relatives, as with one abusive husband in the sample who prevented his wife from calling her friends. Similarly, four of the mothers of abusive children noted that the behavior of the latter became worse when they (the mothers) were on the telephone. As one victim reported: "He makes it hard for me to talk on the telephone. He mimics me while I'm talking. Sometimes I just throw the phone down." This is serious indeed, for the telephone is frequently the most important source of contact for the elderly.

In general, social contact was limited not because the abuser forbade it, but because others found the erratic and antisocial behavior of the abuser threatening. As one abused wife reported: "I'd like to be able to go out and enjoy myself, but my husband always gets drunk. Our children used to take us out, but now my son says he can't stand the sight of him. And I don't blame them for not caring, the way he acts. Even the grandchildren don't care anymore... The family keeps away, and that hurts."

Similarly, an abused mother stated that "It's hard to invite people over. I'm embarrassed. He talks out of line sometimes. Another woman quit her "Friendly Club" because her daughter-in-law would "start screaming" whenever the club met in her home. In a third case, the husband's bizarre behavior frightened his son's child so badly that he was never brought back to the house. The abuser can thus be a key factor in reducing the elderly person's contact with the outside world. A viscious circle may then exist: persons who might be able to intervene to ameliorate the situation are driven away, which allowed the abuser's behavior to worsen: this in turn leads to further isolation.

What conclusions can be drawn from all of this information regarding social isolation? The data provide some support for the hypothesis that abused elders have more limited social contacts: they scored lower on the CONTACT sub-scale, and were less likely to belong to a church, bluc, or other organizations. However, on the other components of the Social Resources Rating Scale, no significant differences were found. Further, none of the items on the scale taken individually appear to be good predictors of abuse.

Further, it was noted that diminished contact appears to be related to the abuser. These relatives' behavior, and the general level of conflict in the relationship, scare off would-be helpers. Such actions on the abuser's part may be related to characteristics noted above: emotional instability, alcohol abuse, and dependency. Although this observation is highly speculative, perhaps the dependent kin see outside persons as a threat to their position vis a vis the victim, and purposely discourage their visits or calls. Such intentions would be consistent with the picture of the abusers obtained thus far.

I. Summary

In this study, 42 physically abused elderly persons were matched with a non-abuse control group to identify factors associated with this type of maltreatment. The nature and extent of verbal aggression and physical violence were measured, and five potential causes of abuse were examined: intraindividual dynamics, intergenerational transmission of violence, dependency, external stress, and social isolation. It will be useful here to briefly recapitulate the major findings.

- Nature and extent of violence. The individuals identified by case workers as victims had in fact been subjected to extensive verbal aggression and physical violence. They were unlikely themselves to have used violence against the abuser. Case workers' and victims' assessments of types of violence that had occurred were very similar.

- Intraindividual dynamics. The abusers were much more likely than the comparisons to be identified as having mental and emotional problems, and as abusing alcohol. They were also more likely to have been hospitalized for psychiatric reasons.

- Intergenerational transmission. Findings in this area were not significant. Abused elders did not report more physical punishment of children, nor did they indicate that the perpetrator had been a victim of child abuse.

- Dependency. Abused elders were not found to be more ill or functionally impaired than the control group; in fact, they were less impaired in a number of areas. The abuse group was not more dependent on their kin than the comparisons for ADL assistance. However, the abusers were more likely to be dependent on their elderly victims than were the control relatives.

- External stress. These findings were somewhat ambiguous. While abusive families were more likely to experience three stressors (someone moving in, someone leaving, and someone getting arrested) these were actions of the perpetrator directly related to the abuse situation. The other, truly external events did not significantly differ between the two groups.

- Social isolation. The abuse group scored more poorly on three of the five Social Resources scales. They had fewer overall contacts and were less satisfied with those they did have.

As this summary shows, two hypotheses received strong support: that elder abusers would be more likely to have mental or emotional problems, and that they would tend to be more dependent on their relative than the controls. One hpoythesis received more limited support: abused elders were, to a degree, more isolated. However, they were as likely as the controls to have someone to help them in a crisis, and did not score significantly lower on the overall Social Resources Rating Scale. Two hypotheses--intergenerational transmission of violent behavior and external stress--were not supported by the data.

With the presentation of the results of the indepth analyses of the selected physical abuse cases and comparison group, the focus of this Final Report now shifts to organizational issues and endeavors. Chapter Seven which follows explores the organizational structure of the three Model Projects; Chapter Eight describes the methodology and results of the second survey of community agencies carried out by the Model Projects; and Chapter Nine elaborates on some of the additional activities carried out by the Evaluation Team. In Chapter Ten, the findings from all the various tasks are summarized, including some further discussion on the indepth case analysis and the future directions for research, policy and practice are suggested.

CHAPTER SEVEN

ORGANIZATIONAL ANALYSIS OF THE THREE MODEL PROJECTS

I. Introduction

In order to evaluate the impact of the Model Projects, it is necessary to describe what they are, and what they do. As two evaluation specialists have noted (Morris and Fitz-Gibbon, 1978), even if the outcome analysis demonstrates that a program was successful, it is incomplete without detailed information about the program itself. Outcome data, they assert, might lead one to assume the program "worked." They continue:

> Unless you have taken care, however, to describe the program's myriad facets, you will be unable to answer the question that logically follows your judgement of program success. That question would ask: "What worked?" If you cannot answer that question, you will have wasted effort measuring the outcomes of an event that cannot be described and must therefore remain a mystery (p. 10).

In Chapter Five, the extent to which the Model Projects altered the situation of the abused and neglected elders in a positive way was described. It is the goal of this chapter to provide a picture of the Model Projects in actual practice. Four major areas of inquiry are highlighted:

1. Major Features of the Project.

   What are the principal components of each Model Project? How does each Project operate on a day-to-day basis? What are the major activities of the staff? What services are provided by the Project?

2. Implementation.

   What is the history of each Project? What unique factors in the service environment influenced its development? What implementation problems were encountered? How were such problems overcome?

3. Intra-agency Coordination.

   What is the relationship between the Model Project and the agency in which it is located? What impact has the Model Project had on the agency? Have other agency personnel had any difficulty accepting the Model Project?

Figure 4 Persons Interviewed For Organizational Analysis

	WORCESTER	SYRACUSE	RHODE ISLAND
Model Project Staff:	Project Director Social Worker	Project Director Social Worker	Project Director Social Worker
Other Personnel in Agency Sponsoring Model Project:	Executive Director Assistant Director Case Managers(2) Supervisor Intake Services Supervisor	Director, Alliance Director, Elder Services of the Parish Division Social Worker Aide Supervisor Elder Abuse Aides(2)	Executive Director Intake Planner Director of Planning Assistant Director of Planning
Personnel in Other Agencies:	Director, Clinical Services, VNA Asst. Director, Jewish Family Services Director, Senior Law and Advocacy Project Social Worker, Geriatric Services Social Worker, Friendly House	Exec. Director, Metro. Commission on Aging Planner, Metro. Commission on Aging Administrative Supervisor, Adult/Family Serv. Unit Supervisor, Adult/Family Services, DSS Director of Elderly Serv. Huntington Family Center Director, Home Care Serv. County Health Department Public Health Home Care Supervisor, County Health Department	Coordinator of Elderly Services, Prov. Mental Health Center Social Work Consultant, Providence VNA Casework Supervisor, Dept. Social/Rehab Services Head Social Worker, Federal Hill House Lieutenant, Providence Police Dept.

4. Interagency Coordination.

How does coordination with other agencies take place? How does each Model Project interact with other agencies in the areas of referrals, service utilization, and ongoing case management? What sorts of formal and informal linkages exist?

II. Methodology

A number of different data collection techniques were employed to answer the above research questions. The major component involved indepth interviews at each of the three sites, which were tape-recorded and transcribed. They included open-ended questions relating to the research questions. Three groups of people were interviewed: Model Project staff; other staff in the same agency as the Model Project, and personnel in other community agencies. All interviewees were suggested by Model Project staff. (Figure 4 presents persons interviewed for this study.)

In addition to the taped interviews, Model Project staff and the personnel from other community agencies were administered a standard assessment tool, the Organizational Assessment Instrument (OAI), which was adapted for this study (Appendix I, Exhibit 6). The OAI identifies organizational characteristics that explain the effectiveness of an organization and the quality of work life (Van de Ven and Ferry, 1980). The version of the OAI given to Model Projects staff asked questions relating to basic work activities and type and quality of contact with others in the agency and in other agencies. The form given to other agency personnel requested them to evaluate their contact with the Elder Abuse Project. A third methodological component involved a time study (Appendix I, Exhibit 7). In order to better understand how the Model Project staff functioned, they were asked to keep a daily report of their activities for the month of February, 1983.

III. Results

A. Major Features of the Model Projects

This section begins with a discussion of features shared by all three Model Projects. Actually, the basic design elements (basic goals, target population, and staffing) are quite similar between the Projects. However, in specific characteristics, the Projects differed substantially. In the later sections of this chapter, the unique features of each model are presented.

Common Elements

The Model Projects shared similar objectives that they attempted to achieve throughout the course of the demonstration. All three projects had the primary purpose of providing casework services to abused and neglected elderly (60 and over) and members of their families. The goal was to intervene in cases of maltreatment, to introduce services where appropriate, to counsel victims and relatives, and to help resolve conflict between abuser and abused. In addition to this objective, the Model Projects were also to fulfill the important function of coordination among other service providers. They were to serve as a focal point for attempts by local agencies to help abused clients. Finally, all three Projects had as an objective education of community residents regarding the problems of elder abuse and neglect. Each was to organize training and informational sessions on the topic.

Thus, one common element of the Projects was similar objectives. A second point of similarity was the target population to be served. First, the Projects only handled abuse and neglect in domestic settings; maltreatment in institutions was beyond the scope of the project. Also excluded were self-neglect or abuse; the Projects were only concerned with abuse by others. Second, the Projects employed identical definitions of abuse and neglect. (See Figure 1). Finally, the staffing and funding of the three Projects were similar. Each Project was funded to employ a half-time director and a full-time caseworker. Certain differences did exist in staffing patterns, however. For example, the Syracuse Project received funds from a local agency which permitted them to hire a full-time director. Along the same lines, Rhode Island was able to employ an Information and Referral specialist.

In each of the subsequent sections the special characteristics of each Model Project are detailed. Following this, a case example is provided to illustrate the features of the intervention model. Finally, a flow chart of the progress of a typical client through the Project ("client pathway model") is presented and discussed. Further information on the operation of each Model project is given in Section B, which involves an analysis of the staff's major activities.

Before proceeding, one general comment must be made. From the study of these Projects, it is apparent that in spite of similarities, each represents a specific service approach to elder abuse and neglect. It is possible to identify these models as follows. The Worcester Project employs what might be termed a "service brokerage" model, in which the agency has direct control over a wide array of services that can be used to help resolve a case. A major function of the Project has thus been to introduce and manage these services. The Syracuse Project follows a "coordination" model. While all three Model Projects fill a coordinating role to some degree, the Syracuse Project has made this aspect the core of its efforts. Rhode Island's approach can be considered a "mandatory reporting" model, in that it is the only project that operated under a mandatory reporting law.* As the unit designated to respond to abuse reports, the Rhode Island Project emerged as a distinct model. It would be, to be sure, misleading to characterize the Projects as three generic, totally distinct intervention models. In fact, all three models acted to some degree as service brokers and coordinators. To the extent, however, that each Project adopted a special focus in its activities, these labels accurately distinguish the models.

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*In July of the last year of the demonstration (1983) a mandatory reporting law was passed in Massachusetts. The data for the organizational analysis, however, were collected prior to this law's passage.

Massachusetts: A Service Brokerage Model

The Massachusetts Project is located in Elder Home Care Services of Worcester, a large multi-service agency that provides non-medical home care services to persons over the age of 60. It is important to note that Elder Home Care Services of Worcester (EHCSW) is a "Home Care Corporation" (HCC), a type of service provider unique to Massachusetts. In order to understand the nature of the Worcester Project, it is necessary to briefly describe the HCC system. The Massachusetts Department of Elder Affairs maintains purchase agreements with 27 HCCs across the state. While many HCCs are also agencies on Aging, EHCSW is not. HCCs provide case management and information and referral services directly, and contract for a range of other services, including homemaker and chore services, transportation, congregate and home-delivered meals, and legal aid.

Case management is a particularly important component of the HCCs. All clients who request services are initially prescreened by intake workers. If the client meets basic eligibility guidelines, he or she is referred to a case manager. Using a standard form called the Comprehensive Needs Assessment Procedure (CNAP), the case manager performs a detailed assessment of the client. Based on this evaluation, a plan of care is developed which must be approved by a HCC supervisor.

Applicants who are determined to be ineligible for HCC services are assisted by an information and referral specialist in finding another appropriate provider. Clients who are accepted are assigned a permanent case manager, who, in addition to developing the case plan, is responsible for initiation and monitoring of service delivery and periodic reassessment of client need. Clients are monitored by case managers until their case is closed due to death, institutional placement, or lack of need for services.

Prior to the institution in July 1983 of a statewide mandatory reporting requirement for elder abuse, most HCCs did not have specially trained protective service workers. Instead, each case manager handled the few cases of maltreatment which would randomly appear in their caseload. EHCSW departed from this basic model when it instituted first a Crisis-Intervention Project and later the Elder Abuse Project. It thus offered case managers an unusual opportunity to seek assistance in abuse and neglect cases, or to transfer cases entirely.

The Elder Abuse Project at EHCSW works as part of a protective services unit. That unit contains the elder abuse social worker, a crisis-intervention worker, and a director who devotes half his time to the supervision of each of these workers. He also takes a certain number of cases on his own. This historical development of this structure is detailed in Section D. Briefly, in 1977, EHCSW employed a social worker to do protective services ("crisis intervention") work with the elderly. That worker handled abuse and neglect cases, as well as problems such as evictions, other legal problems, family difficulties, and so forth. When the agency received the elder abuse grant, it was able to hire another social worker and a half-time administrator. Due to the narrow scope of the Model Project, the new social worker could only take on cases of abuse and neglect by others; self-neglect and abuse were left to the crisis-intervention worker. As noted above, the director devotes equal time to both types of clients.

An important feature of the Worcester Model is that for many clients, Model Project staff serve as the HCC case manager. If an abuse case is referred from another agency, the social worker or director will perform the initial assessment, develop a plan of care, and initiate services. Thus, the elder abuse workers have a unique ability among the Model Projects to provide the client with concrete services. If the abused individual meets eligibility requirements, the worker can provide them immediately with a homemaker, home-delivered meals, or other services. This is extremely critical, as the EHCSW abuse worker has the ability to offer a client concrete assistance in addition to counseling or legal intervention.

In many cases, Worcester abuse cases are often eligible for state-financed home care services. However, some abuse cases are financially ineligible for services, or are unwilling to go through the application process. In that case, the elder abuse workers attempt to bring in services in some other way: for example, some services are financed by Title III, and thus have no financial eligibility guidelines. Other services are financed directly from the elder abuse grant. Elder abuse workers can thus call on two full-time geriatric aides funded by the the Project; these aides can be deployed without the cumbersome eligibility determination process.

As will become apparent below, it is this access to services that differentiates Worcester most clearly from the other Projects. The Rhode Island Project has limited access to a service component of this type, while the Syracuse Project makes use only of specialized aides. The Worcester Project alone is able to directly authorize a wide range of services to a client.

Homemaker services are the most frequently used. They can generally be authorized up to four hours a day, five days a week. Thus, Worcester staff can effectively-monitor an abuse or neglect situation through the homemaker, while relieving stress on the parties involved by helping them with cooking, cleaning, and food shopping. Meals-on wheels, chore services, and friendly visitors are also used by staff to perform a monitoring function.

Beyond providing services, staff in the Worcester Project attempt to establish a counseling relationship with both abuser and abused. Often, the worker will be involved with a client for a long period of time, and will assist them in taking steps to improve their situation. Further, the relationship can go beyond a standard therapist-client relationship:

Worcester Project staff often provide a wide range of assistance to clients. As one worker commented:

> Although its a professional relationship with the person, it also has a quasi-personel feeling about it. I think many times, we can have the flexibility to do things, like take someone in our care if it's necessary, and just do little personal things like that. That's the kind of stuff that goes to the core of the relationship, and what I consider to be a real important feature.

It is important to point out that as a result of these features, Worcester Project staff tend to have long-term relationships with their clients to a greater degree than the other sites. Since the abused individuals are likely to become clients of the *agency*, as well as the abuse unit, opportunities for monitoring and follow-up are greater. Perhaps for this reason, Worcester served fewer total abuse and neglect cases than the other two Projects. This may be due to a more enduring and intensive relationship with the clients who were seen.

In summary, the Worcester Project has a number of distinct characteristics. First, it is located in a large elder service agency. As workers in that agency, Project staff have considerable leeway in using a wide array of services to intervene in abuse situations. They also counsel clients and assist them in a variety of other ways. Because of the nature of this Project, involvement with clients tended to be long-term. One additional aspect of the model - coordination of the activities of other agencies - is discussed in a later section. As a way of making this somewhat abstract discussion more concrete, a specific case example will be presented here. Following this case, the typical flow of a client through the Worcester Project will be described, using the client pathway model.

Case Example. The case to be described here involved Agnes, a 63-year old woman who lived with her brother Edward, also in his sixties. Another sister had originally referred her to the Crisis Intervention worker. The sister felt that physical abuse was taking place; she reported that her sister's glasses had been broken, and her face was bruised. She also informed the Crisis Intervention worker that the brother would talk about having to "discipline" the sister. The Crisis Intervention worker promptly referred this case to the Elder Abuse Unit, and ceased to be involved in the case.

The elder abuse team took on the case, and ascertained, that physical abuse had indeed occurred. Edward complained that Agnes "drove him crazy" by following him around the apartment and leaving notes for him. While she was working, he claimed, things had been fine. Her health status, however, had recently declined to the extent that she had been forced to quit her job, and was now virtually homebound. He was also angry that her only financial contribution to the household was her social security check. As a result of these strains, the brother would, according to the caseworker, "lose his ability to cope." He would then, lash out violently on occasion.

The abuse unit arranged for a psychiatric evaluation. The psychiatrist reported that the abuser had serious psychiatric problems. At this point, the two abuse workers decided to split the case, with the social worker taking Agnes as her client, and the Project Director, Edward. They quickly found the brother to be openly threatening towards his sister, and the two argued violently. In fact, their repeated verbal battles had brought them to the verge of eviction from their apartment. Through interviews with the clients and contacts with other involved agencies, the abuse workers learned that the brother had been in a mental hospital for over twenty years, and was discharged into his sister's care. This tenuous arrangement broke down, as noted above, when the sister became unemployed. Based on their assessment of the situation, the major goal of the abuse workers became the permanent separation of the two clients.

Before that could be accomplished, the police intervened during a particularly bad fight. The abuser was jailed overnight. The Project director met with him and attempted to persuade him to move away from his sister. He refused, citing his reliance on his sister's social security income. During this time, the abused woman moved in with her sister. The director assisted the brother, even appearing with him in court, and helping him get a continuance, on the condition that he undergo psychiatric treatment.

The social worker continued to work with the abused, who was now residing with her sister. The worker arranged for a geriatric aide to be sent in three times a week. She also attempted to enroll her in an adult day health program, but this was not successful, due to the client's agitation at the center. During this period, the sister with whom Agnes was temporarily residing became increasing hostile and uncooperative. It became apparent that another living situation would have to be sought. The social worker continued to work with Agnes, and provided her with additional services. She arranged for more psychiatric visits, and obtained dentures for the client. Agnes also received home health services, and the social worker stayed in close contact with the Visiting Nurse Association for coordination purposes.

The appeared to be approaching resolution when Agnes expressed a desire to enter a nursing home. The social worker packed her belongings and took her to a facility with an available bed. As the intake process dragged on, the client became increasingly upset, and demanded to be taken back to her sister's home. At this point, the abuse unit learned of other relatives of the abused client, who lived in Kentucky. They were contacted, and were very concerned about the situation. They came to Worcester, and worked in intensively with the Model Project staff. The relatives were granted guardianship of Agnes, and took her back with them to Kentucky where she was placed in a nursing home.

Throughout this time, the Model Project Director worked with the brother. He did financial counseling with him, and assisted him in locating new housing. The brother was able to continue living independently, without the assistance of his sister.

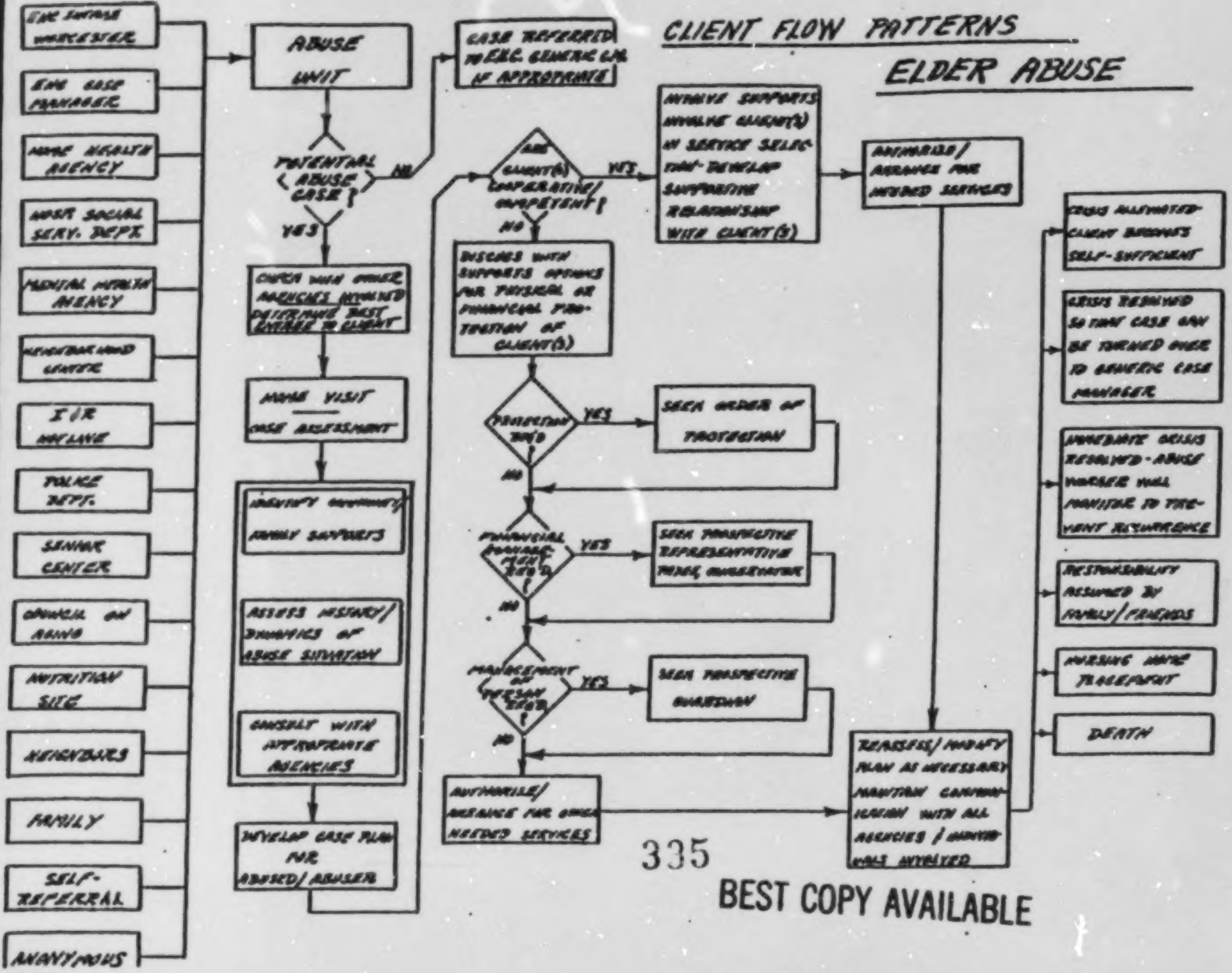
A number of features of the Worcester Model are illustrated by this case. First, the staff brought in services (geriatric aide, legal) over which they had direct control. Second, they engaged extensively in coordination with other agencies. In fact, this case involved interaction with a wide array of service providers: a home health agency, the police, the court, legal services, one nursing home, an adult day health center, and a dentist, as well as services provided by EHCSW. This demonstrates the workers' twin roles as service broker and coordinator. Finally, both staff members acted as counselors to the clients, and supported them through difficult life circumstances. While the workers' involvement in this case was perhaps unusually intense, it gives a sense of the broad range of their activities.

Client Pathway Model. As a method of identifying more clearly the operation of each model, each Project was asked to produce a "client pathway model," which shows the typical client flow through the project. These present in outline form the approach of the sites to abuse and neglect cases. (See Figure 5). According to the client pathway model, clients come from a wide variety of referral services. When any of these agencies suspects abuse, the most likely agency in the area to contact is EHCSW. After the referral, Model Project staff verify the existence of abuse and neglect; if no maltreatment is found, the client may be referred into the basic HCC program.

If abuse is identified or highly suspected, the Project's first step is to contact other agencies involved with the client to determine the role the abuse unit should play. If, after such consultation, the Model Project staff determine that their involvement would be useful, they make a home visit. The purposes of this visit are to verify whether abuse and/or neglect are actually occurring; to identify who in the client's support network could be called in for assistance on the case; and to gather detailed information on the history of the case and its current dynamics. Following this visit, additional consultation with other agencies will usually take place.

A plan of intervention is then designed for the case. Often, this involves the introduction of services. It might also include long-range goals, such as separating the abuser from the abused by commitment, institutional placement, or some other means. If all parties in the situation are cooperative, then the agreed upon services are either directly authorized (if they are HCC services) or are arranged for from another agency. If one or both clients are either uncooperative or possibly legally incompetent, various legal alternatives may be pursued, before services can be arranged. The Abuse Unit then follows the case until it is closed for one of a variety of reasons.

Figure 5 Client Pathway - Worcester


CLIENT FLOW PATTERNS
ELDER ABUSE
EHC INTAKE WORCESTER
EHC CASE MANAGER
HOME HEALTH AGENCY
HOSP. SOCIAL SERV. DEPT.
MENTAL HEALTH AGENCY
NEIGHBORHOOD CENTER
I & R HOTLINE
POLICE DEPT.
SENIOR CENTER
COUNCIL ON AGING
NUTRITION SITE
NEIGHBORS
FAMILY
SELF-REFERRAL
ANONYMOUS
ABUSE UNIT
POTENTIAL ABUSE CASE?
NO
CASE REFERRED TO E.H.C. GENERIC C.M. IF APPROPRIATE
YES
CHECK WITH OTHER AGENCIES INVOLVED DETERMINE BEST ENTREE TO CLIENT
HOME VISIT
CASE ASSESSMENT
IDENTIFY COMMUNITY/ FAMILY SUPPORTS
ASSESS HISTORY/ DYNAMICS OF ABUSE SITUATION
CONSULT WITH APPROPRIATE AGENCIES
DEVELOP CASE PLAN FOR ABUSED/ ABUSER
ARE CLIENT(S) COOPERATIVE/ COMPETENT?
YES
NO
INVOLVE SUPPORTS INVOLVE CLIENT(S) IN SERVICE SELECTION - DEVELOP SUPPORTIVE RELATIONSHIP WITH CLIENT(S)
AUTHORIZE/ ARRANGE FOR NEEDED SERVICES
DISCUSS WITH SUPPORTS OPTIONS FOR PHYSICAL OR FINANCIAL PROTECTION OF CLIENT(S)
PROTECTION REQ'D
YES
NO
SEEK ORDER OF PROTECTION
FINANCIAL MANAGEMENT REQ'D?
YES
NO
SEEK PROSPECTIVE REPRESENTATIVE PAYEE, CONSERVATOR
MANAGEMENT OF PERSON REQ'D?
YES
NO
SEEK PROSPECTIVE GUARDIAN
AUTHORIZE/ ARRANGE FOR OTHER NEEDED SERVICES
REASSESS/ MODIFY PLAN AS NECESSARY MAINTAIN COMMUNICATION WITH ALL AGENCIES / INDIVIDUALS INVOLVED
CRISIS ALLEVIATED- CLIENT BECOMES SELF-SUFFICIENT
CRISIS RESOLVED SO THAT CASE CAN BE TURNED OVER TO GENERIC CASE MANAGER
IMMEDIATE CRISIS RESOLVED - ABUSE WORKER WILL MONITOR TO PREVENT RECURRENCE
RESPONSIBILITY ASSUMED BY FAMILY/ FRIENDS
NURSING HOME PLACEMENT
DEATH

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This client pathway model is of course an over-simplification and idealization of what can often be a highly variable process. It does highlight in a general way, however, the major features of the Worcester Model: service authorization, coordination with other agencies and the informal support network, counseling, and case monitoring.

Syracuse: A Coordination Model

The Elder Abuse Project operates as part of a special program within Catholic Charities called Alliance, a child abuse and neglect intervention service. Alliance employs a distinct and innovative model for handling child abuse cases and has received some national attention due to the effectiveness of its approach. The Elder Abuse Project is based on the Alliance model.

The Alliance child abuse project was begun in 1972. It coordinates all phases of child abuse, from infancy to age 18. All referrals are received from the Child Protective Services division of the local office of the New York Department of Social Services, which has legal responsibility to investigate child abuse cases. The Child Protective Services Division does the actual investigation, but contracts with Alliance to coordinate the investigative process. The latter employs "coordinators" to carry out this function. These individuals put together a "team" for each case, which consists of members of all involved agencies and the family.

Alliance thus serves a primarily coordinative function. It's work is based upon the assumption that the community is rich in services to abusive families, but lacks an entity that puts all the various components of the network together in a coherent treatment plan. Local agencies apparently recognize the need for Alliance's coordinating role in child abuse, as none have refused to participate in the project. The team meets on an average of once a month; at that time, goals set at the last meeting are assessed, and the activities of each team member discussed. The Alliance coordinator calls the team together and facilitates discussion. Each year, over 4,000 team meetings take place.

The Syracuse Elder Abuse Project attempts to apply the Alliance Model to maltreatment of the aged. The stated goal of the Project was to coordinate the activities of agencies involved with abusive families, rather than to offer new direct services. Project staff establish a team for most cases, which usually consists at a minimum of staff from Public Health Nursing and Adult Protective Services. However, in spite of similar goals, the Elder Abuse project differs in a number of ways from the Alliance child abuse model. First, New York has a mandatory reporting law for child abuse cases and a formal investigative procedure that must be followed. Child protective services can also employ legal measures to remove children from a home. Further, the law provides immunity for reporters of abuse of children.

This legal apparatus does not exist for elder abuse in New York, and the role of the Project is therefore less clearly defined. The elder abuse intervention operates on a strictly voluntary basis: if the client or family are resistant, there is little the worker can do. As one Syracuse staff member explained: "Our way of organizing the community response, and the way you have to involve the older client and the family is in a way more delicate, and has to be individually tailored." Since no legal weapon can be employed to force entry into a case, the elder abuse worker must attempt to obtain the family's compliance through persuasion and the development of trust. To be sure, this process occurs in child abuse cases; however, the elder abuse workers do not have similar legal measures to fall back on if all else fails.

The elder abuse model differs from that employed for child abuse in two other ways. First, the team meeting is less likely to include a family member. This is due in part to the physical frailty of the abused (and sometimes the abuser), as well as the lack of legal pressure force them to attend team meetings. The team consists more frequently of service providers. Second, and perhaps because of this, the elder abuse workers do more direct service work and more visits: frail elderly are simply unable to attend team meetings. The usual pattern would be to hold an interagency service team meeting, after which the person most trusted by the client will telephone or make a home visit.

The central component, then, of the Syracuse model is coordination. There is a second aspect of the program that is also extremely important: the use of specially trained aides who visit abused individuals in their homes. In our interviews, community agency staff repeatedly praised the aides. Almost from its inception, Alliance has employed "parent aides" for child abuse cases. These aides go into abusive homes and at as positive role models for parents, as well as assisting them in household tasks in such a way as to reduce the level of tension in the household.

The elder abuse aides function in much the same fashion. The individuals employed by the Model Project have all had long experience as child abuse aides, and therefore are used to difficult domestic settings. The aides spend approximately two to four hours per week in the client's home. Their function includes providing friendly visiting, socialization, and advocacy for the client. The aides also work with the abuser and other family members to provide respite from caregiving and to model move effective ways of communicating.

The interviews with aides showed an extremely high level of commitment to work with the eldely, as well as lengthy experience in dealing with situations of abuse and neglect. The aides described their relationships with clients in similar terms. One noted that: "I talk with the clients, listen to their frustrations, and try to problem-solve." Another reported that "We lend a ready ear when no one else is there to listen." In this role, according to one aide, "We don't think of ourselves as counselors, but as friends who have information about services and some knowledge we can share."

Aides may perform a variety of other services for clients, in fact, this flexibility is seen as a key to their success. Thus one aide took her elderly client to get her hair done, while another procured a reading light for an older person. Equally important, the aides generally attempt to establish a relationship with the perpetrator of the abuse or neglect. One aide reported: "At the start, we went in primarily as an advocate for the elderly. Now, we kind of ride the fence on a lot of these cases. You're an advocate for the caretaker, as well as the elderly."

In addition to the training that the aides received as part of the child abuse program, they also must take a special educational component relating to the elderly. This takes the form of an initial one-day training, and on-going training sessions occasionally throughout the year. All the aides interviewed felt the training was adequate. In spite of the frequently cited effectiveness of the aide component, the aides themselves noted some problems in their intervention. Primarily, their role in child abuse cases is much better defined, due to the legal sanctions available in such cases. One aide asserted: "It's more difficult to work with the elderly. With child abuse, because of the court order, people accept me whether they want me or not. With the elderly, you have to get them to accept you." Another aide expanded this: "Say someone is withholding medication. If it's a kid, it's reportable, but not with the elderly. Or once, one of my clients had a black eye. With a child, I would have reported it, and somebody would have been in there."

Such problems do not appear to significantly hamper the aides, however, as community agencies were unanimous in their praise of them. To give an example, one individual asked the interviewer to "put in a plug for the aide service:" He differentiated the elder abuse aide from home health aides available from the Public Health Department, and asserted:

> When you have a case where the successful resolution of that case is going to involve the acceptance of the aide, and you have a choice between sending in an Alliance aide or one from the Health Department, the chances are that the Alliance aide is going to be able to engage the client and get them to accept services. You're never sure with the Health Department.

In summary, two basic components stand out in the Syracuse model. The first is an emphasis on interagency coordination, highlighted by the construction of a formal service team for most cases. The second is the use of specially trained aides. The importance of both these elements will become clearer in the case description and client pathway model.

Case Example. The case to be described was referred to the Project by a county Public Health Nurse who described the situation as "volatile." The Adult Protective Division of the Department of Social Services screened the case and confirmed the presence of abuse. Following this the Elder Abuse Project coordinator made a visit with the Public Health Nurse. The coordinator identified herself as a Catholic Charities worker, and avoided mention of elder abuse. Based on this visit, the coordinator decided to become involved in the case.

The two individuals involved in the abusive relationship were Edna, age 79, and Jack, age 81. They had been married for 53 years, and had had no children. By their own reports, the marriage had been a difficult one, and worsened even more when Edna suffered a severe stroke in the summer of 1981. She spent ten months in a rehabilitation facility, and after her return home the tension in the relationship increased. The coordinator learned that Edna's depression, short temper, and difficult personality were often too much for Jack to handle. On occasion, he struck and pushed her, and regularly withheld food and medication from her. Edna could not accept the new limitations brought on by the stroke; her response was to scream, yell, and continually complain. During arguments, Edna would throw food and objects at Jack, which would anger him even more. It was in such situations that he would physically abuse his wife. The coordinator observed bruises and abrasions on Edna's face and arms. Jack admitted having caused "some of them."

Jack was having considerable difficulty adjusting to his wife's dependency on him. He cooked, kept house, did food shopping, and in general tried to take on the activities his wife could no longer perform. While he had a substantial savings, he refused to purchase services that might ease the situation. This, he felt, would be "a waste of money." The only assistance the couple received were morning and evening visits by a high school girl to get Edna out of and into bed.

After acquiring this information, the coordinator called a team meeting, consisting of the Public Health Nurse, Edna, Jack, and the high school student. The situation was discussed, and steps were taken to construct an intervention plan for the case. The coordinator then took the lead role in managing the situation. Based on these early meetings, she determined that the following needs were present: socialization for both parties, time apart from one another; home health aide service, Elder Abuse Aide service; and more regular medical care for Edna. An Elder Abuse Aide was offered immediately for four hours per week, and was accepted. A psychiatric evaluation of Edna was also scheduled. The availability of family and friends was explored, but such informal supports were virtually non-existent. An adult day care center was contacted for Edna, and arrangements made for an access ramp to be built on the house. The psychiatric evaluation team found her "depressed but competent." The depression was severe enough, however, that the day care center did not feel Edna should attend. She cried most of the time she was there. After two days at the center, this service was discontinued.

The most successful aspect of the initial interaction was the Elder Abuse aide. The aide was introduced by the coordinator, and began to make weekly visits of three to four hours. The aide visited with Edna and Jack individually as well as together, to try to defuse the anger both felt and reduce fighting. She provided free time for Jack to leave the house, and accompanied Edna to the adult day health center. She also arranged for a hairdresser to come to the house.

The service team met once a week for the following three weeks. The case appeared to have stabilized, and the team was inactive for two months. At that point, the aide and other service providers began to notice new signs of physical abuse, such as bruises and a black eye. The service team met again, and some new measures were implemented. A worker from Adult Protective Services became involved, and Jack agreed to pay for visits from a Public Health Nurse.

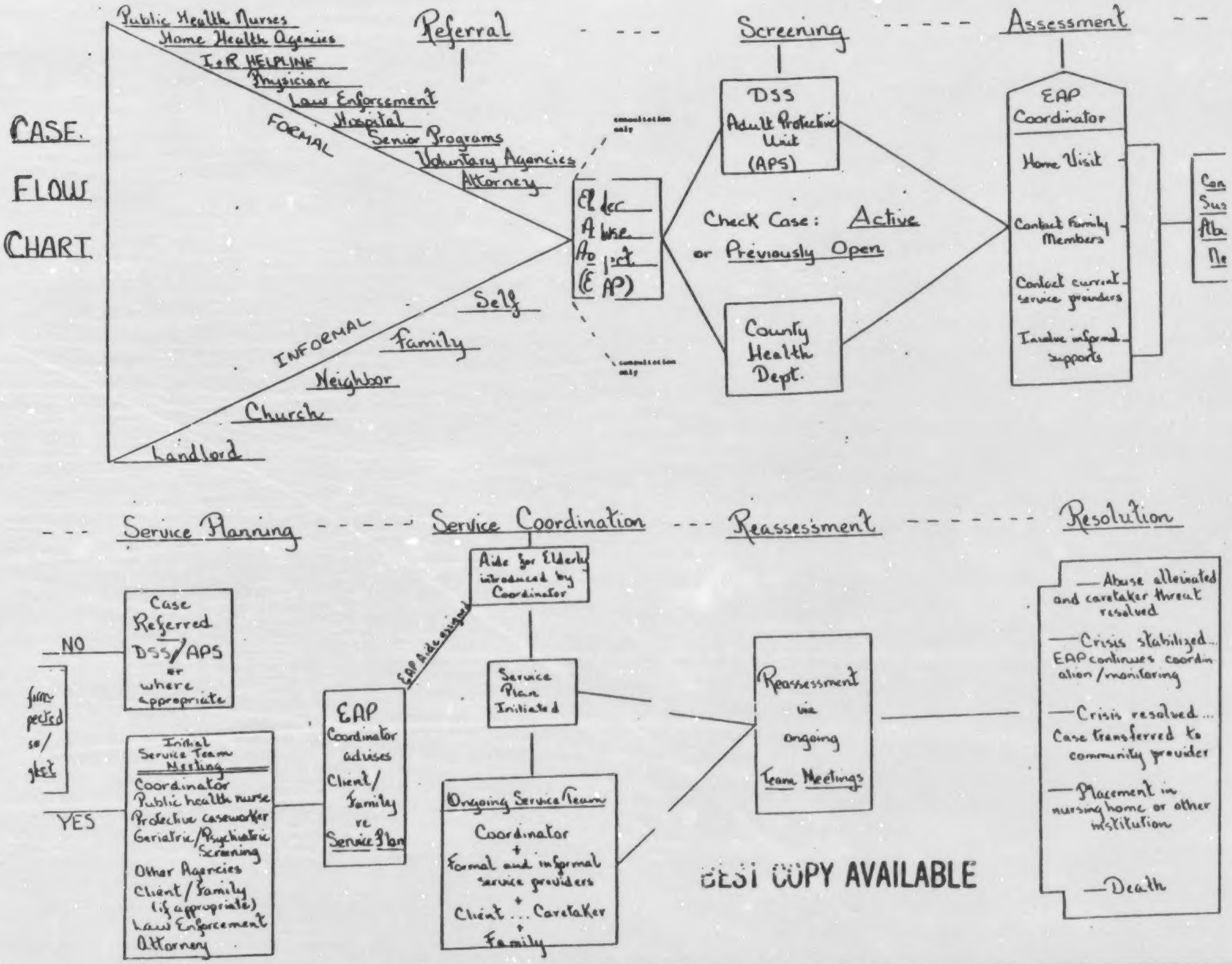
Edna's health problems began to worsen around this time. Because of Jack's withholding of medications, Edna's glaucoma had gone untreated, and her eyesight had begun to fail. She also developed decubitus ulcers. She would at times beg to be taken out of house permanently, but balked at the idea of a nursing home. As her husband refused to pay for nursing home care, she would have to be placed on Medicaid, and Jack sued later for payment. The service team met with the welfare department and got approval to put through a Medicaid application. However, Edna refused to give final consent to a nursing home placement, asserting that she wanted "to stay with Jack." During this crisis, the service team expanded to include the following individuals: Elder Abuse Project coordinator, Elder Abuse aide, Adult Protective Services worker, Public Health Nurse, home health aide, psychiatrist, internist, County Health Department supervisor, Department of Social Services supervisor, and Edna and Jack.

The crisis was resolved by the service team in the following way. Edna was given more services, which included several nursing visits each week, four hours a day of home health aide service, and a weekly two-hour visit by the Elder Abuse aide. These individuals insured that Edna received her medications properly and followed a better diet. She was also treated for depression. The privately hired helper continued to come for two hours in the morning and two in the evening. Jack received some services from the Public Health Nurse, who would monitor his heart and blood pressure. He also benefitted from social contact with all the service workers involved with Edna. In addition, the respite care function of the aides allowed him to spend more time out of the house. As a result of all these interventions, the situation has stabilized, and physical abuse has stopped.

It should be noted that this case was more complicated and difficult to resolve than many others Syracuse has worked with. However, it is useful in that it shows the features of the Syracuse model in very clear relief. First, the Elder Abuse Project worker took the lead in case coordination, juggling a dizzying array of services and agencies. Second, the role of the service team is highlighted in this case: regular team meetings proved crucial to the intervention strategy. Finally, the Elder Abuse aide played an important part, both as paraprofessional counselor to abuser and abused, and as a monitoring agent. It was, in fact, the aide who alerted the team to the recurrence of abuse after the initial resolution. The client pathway model also highlights these elements.

Client Pathway Model. Clients are referred to the Elder Abuse Project from a wide variety of agencies (Figure 6). The Project will then coordinate screening with either the Adult Protective Unit or the County Health Department. If it is determined that abuse or neglect is a possibility, the coordinator will then conduct a comprehensive assess-

Figure 6 Client Pathway - Svracuse


CASE
FLOW
CHART
Referral
Screening
Assessment
Public Health Nurses
Home Health Agencies
I&R HELPLINE
Physician
Law Enforcement
Hospital
Senior Programs
Voluntary Agencies
Attorney
FORMAL
INFORMAL
Self
Family
Neighbor
Church
Landlord
consultation only
consultation only
Elder Abuse Project (EAP)
DSS Adult Protective Unit (APS)
Check Case: Active or Previously Open
County Health Dept.
EAP Coordinator
Home Visit
Contact Family Members
Contact current service providers
Involve informal supports
Con
Sus
Ab
Ne
Service Planning
Service Coordination
Reassessment
Resolution
NO
YES
Case Referred DSS/APS or where appropriate
Initial Service Team Meeting
Coordinator
Public health nurse
Protective caseworker
Geriatric/Psychiatric Screening
Other Agencies
Client/Family (if appropriate)
Law Enforcement
Attorney
EAP Coordinator advises Client/Family re Service Plan
EAP Aide assigned
Aide for Elderly introduced by Coordinator
Service Plan Initiated
Ongoing Service Team
Coordinator + Formal and informal service providers + Client ... Caretaker + Family
Reassessment via ongoing Team Meetings
— Abuse alleviated and caretaker threat resolved
— Crisis stabilized... EAP continues coordination/monitoring
— Crisis resolved... Case transferred to community provider
— Placement in nursing home or other institution
— Death

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ment. This assessment involves not only a home visit, but also contacts with other persons involved in the client's life. Based on this evaluation, the coordinator determines whether abuse or neglect is present. If neither abuse nor neglect are found, the client is referred to another appropriate agency.

In cases in which maltreatment of the elderly person is confirmed, the coordinator often convenes a team meeting. This usually involves, at a minimum, an Adult Protective Services worker and a Public Health Nurse. Whenever possible, the abused client and family members are also involved, but this is not generally the rule, for reasons noted above. A service plan is developed at the team meeting, and is put into effect. An aide may be introduced, and the client's relatives may be referred to a caregivers' support group sponsored by Catholic Charities. Throughout the remainder of the time the case is active, the team periodically meets to reassess the situation. Alterations in the service plan are made as needed. This continues until the case is resolved.

As the ensuing sections will demonstrate, the Syracuse project deviates somewhat in actual practice from the client pathway model. The model is useful, however, in that it highlights the coordinative emphasis of the Project. Unlike the Massachusetts model, Syracuse workers cannot directly authorize a wide range of services. Instead, they are involved in a relatively constant process of negotiation with agencies that do have services at their disposal. The success of the model is therefore dependent on its relationships with other agencies.

Rhode Island: A Mandatory Reporting Model

The Rhode Island EAP was located in the state Department of Elder Affairs (DEA), which is the state agency responsible for responding to the needs of elderly residents. It serves the entire state, and receives federal, state, and local funding. The EAP was located in the Program Planning Division of DEA. Six months after the inception of the EAP, the Rhode Island General assembly enacted a mandatory reporting law. This law mandated that the Department receive reports, carry out an investigation of suspicious cases, and coordinate with other service providers.

As originally conceived, the intervention model in the Rhode Island EAP consisted of the following components:

1. Calls reporting Elderly Abuse would come into the DEA Information and Referral System.

2. DEA abuse staff would investigate the report and provide immediate crisis intervention as necessary. Other support staff at DEA, (Long Term Care Ombudsman, Legal Services Developer, In-Home Service Coordinator, etc.) would be available to assist abuse workers.

3. DEA abuse staff would contact any agencies involved with the family or individual and also contact local community

> agencies that had resources available. A care plan would be developed, a lead agency for case management would be identified, and this agency would take on the responsibility of implementing the case plan.

The DEA abuse staff would follow up on each case at regular intervals and provide technical assistance and support when requested by the case management agency.

Clients who were already recipients of Supplemental Security Income (SSI) have access to a social worker through the Department of Social and Rehabilitative Services (SRS). DEA realized that community resources for case management are limited, and that the caseloads at many local agencies (senior centers, nutrition projects, VNA's, etc.) are quite heavy. Therefore, it was seen as unnecessarily duplicative to assign case management responsibilities to a local agency when the client had, or was entitled to, an SRS worker. Clients without an SRS social worker were assigned to other local agencies. It is important to note that a wide variety of services are provided by DEA. These include:

1. Information & Referral - statewide, including housing
2. Long Term Care Ombudsman
3. Emergency Shelter (offered during the three year Abuse Project)
4. In Home Services (Homemaker/Home Health Aides for categorically eligible clients).
5. Senior Companion Program - Assignment of companions to homebound older persons.
6. Low Income Energy Assistance (for residents of Providence only - referral available for other parts of the state).

However, the EAP staff did not have direct control over these services. Unlike the Worcester EAP, Project workers in Rhode Island could not personally authorize services.

As mentioned noted above, the Rhode Island EAP was the only Project that operated under mandatory reporting. At the risk of oversimplification, this legal responsibility has been identified as one of core elements of the Rhode Island EAP. The coordinating and counseling activities performed by the Project staff were shaped by the fact that it was a statewide project operating within a state agency, under mandatory reporting.

Some of the effects of this situation were noted by the EAP staff. The Rhode Island model has a primarily short-term focus and relies on extensive coordination with other agencies to provide on-going direct services. The major roles of the EAP are to act as a catalyst for intervention and to remain with the case until the abuse situation is alleviated and follow-up completed. When suspected cases of abuse/neglect are referred to DEA, EAP staff are required to initiate investigation within 24 hours. Staff investigate and assess each case, and attempt to establish a care plan in cooperation with other agencies.

This mandatory reporting aspect becomes clearest in the comments of other agencies on the Project. When asked why she contacts the Project, a social worker responded:

> Because DEA has the mandate to investigate and coordinate services the way the law is written. So it's a matter of following the law. We certainly want to provide what's best for the client, but we do so after checking it out with DEA, or in consultation with them, or at their request, because of the way the law is written.

A worker at a senior center, in answer to the same question, replied "It's the central point to report incidents." The response of a social work consultant from a Visiting Nurse Association shows this formal responsibility even more clearly: she would report cases, but try to keep the Project staff from intervening. Her concern was with fulfilling the letter of the law. She reported:

> What I find is, in a few cases, when we make the report, I'm already working with the nurse on it. By the time the nurse feels something is going on, she already has a good relationship with the person, and so a lot of times I'll report to the Elder Abuse Project but I'll say "Don't go in . . ." I tend to report all suspected cases . . . but I feel comfortable asking them not to go out.

In this case, perhaps most clearly, the Project is seen as the official recipient of calls, rather than an integral part of an intervention strategy. Another respondent echoed this; when asked if she would report a case to the Project if the law did not exist, she replied: "We wouldn't feel so bound. We use the program to a large extent because of the law."

A second aspect of the Project is also related to its legal mandate: this is what some interviewees referred to as its "clout." One community agency interviewee reported: "Being from DEA has clout. Just the fact that DEA is involved has changed the behavior of family members." Another respondent echoed these sentiments: "There are situations when families are scattered and unresponsive. When DEA goes in and calls them together, they tend to straighten up. They have some clout."

With this emphasis on the Project's legal responsibility in mind, it is possible to review other basic features of the model. When suspected cases of abuse and neglect are referred to the project, the staff are required to investigate within 24 hours. These referrals are first screened by Information and Referral (I and R) workers. According to the director of the I and R service, the screening is generally straightforward, as callers usually specify that they are reporting abuse or neglect. He noted: "The Elder Abuse Program is visible, so most of people have a pretty clear idea of why they're calling. It's very rare that a person asks about one thing, and then, in a long conversation, you find abuse is going on, too."

After preliminary screening, the I and R worker refers cases of abuse and neglect to the elder abuse team. Ideally, all new cases should go to the social worker, rather than the Model Project administrator. In reality, the administrator has developed a caseload of her own. This is in part due to the fact that the original social worker left the Project after approximately one year and the administrator had to take on cases until a new one was hired. In addition to cases which come in through the I and R unit, both staff members receive referrals directly from agency staff who are acquainted with them. Workers in other community agencies often prefer to circumvent the I and R unit and speak directly with Model Project staff.

The Model Project social worker summed up the next steps in case intervention as follows:

> After I receive a complaint of abuse, with the information I have, I decide what my next step will be. If there are other agencies involved, I'll call them. If there are family members involved, I'll call them. If it's a physical violence case or a matter of personal safety, I immediately go to visit the home.

she continued:

> After an I and R referral, I will call whatever numbers are on the I and R form. If the person is on SSI, say, I know they must have a social worker, so I'll call the Department of Social and Rehabilitative Services.* Before I go to the house, I try to get as much information as I can. For example, when I went to one case where the husband and wife were beating on each other, I stopped at the police station first to see if they knew of them. They said it had been going on for six years. So I do a little investigation prior to going in to the home. Unless its an emergency, then I just go.

The emphasis in this service model is investigation: the Project was the responsibility to determine if abuse occured and, if it has, to set a treatment plan in motion. Staff may also serve a coordinating role, but to a more limited extent than in the other Model Projects. When asked whether other agencies look to the Project for coordination, the social worker responded:

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*Administers welfare program

> Sometimes. But sometimes it would be very inappropriate. For example, in one case I was one of the people involved, but the person who organized meetings with the family was the nurse there. It was appropriate because that was her community and they all knew each other.

She added:

> Every case is different. You have to assess the resources, assess the roles, and assess your role constantly in each case. It's usually very evident what your role should be . . . sometimes you lay back and function as a part of it; sometimes you get the people together.

Because of the mandatory reporting law, Project staff may be informed of the case, but not take a major case management role in it. In the other Model Projects, a call to staff is generally a request for heavy involvement and probable on-going case management.

Another aspect of the Project is the usually short-term involvement Project staff have in cases. The Project social worker was asked whether an attempt is made to get other agencies to take over the primary responsibility fo a case quickly. She replied:

> Yes. They have to. My primary responsibility is to investigate the abuse, and through whatever means I can--peaceful at first, negotiating second, and by legal means and threats last of all, to eliminate the abuse . . . when other agencies take over, we tend to withdraw.

Other agencies substantiated this; the Model Project is seen as having a short-term, crisis-intervention focus.

There are two major reasons for this aspect of the Model Project. First, unlike the other two Projects, Rhode Island staff have no direct access to services. The Worcester Project can authorize a wide range of services, and Syracuse at least can make specialized aides available. In such a case, these providers often take over the coordinating function as a natural outgrowth of their direct service activities. Second, the Rhode Island Project receives a massive number of referrals: over 400 since it began operating. Staff is clearly unable to have an intensive involvement in each cases. In order to carry out an investigation of each call, they must delegate major portions of the day-to-day intervention to other agencies. As a Social and Rehabilitative Service supervisor noted: "We see them as having the mandate and the authority to do something, and we want them to know what's going on. But a lot of the day-to-day stuff we do ourselves. They couldn't do it, because of their limited staffing."

It is interesting to note that the EAP was aided in the investigative process by other agencies. As the Project director reported: "We must investigate. But the investigation can take many different forms. According to the Project director:

> It would be impossible for us to go into any home on a one-time basis and be able to find out all the ramifications of that case, and if you've got a direct service person who's been going in to see this person over time, they definitely would have a hell of a lot more information than we ever would. So that our best advantage is to find out from them and coordinate with them. We depend on other agencies, like Social and Rehabilitative Services, VNAs, or the police, to do valid assessment.

The key features of the Rhode Island Model Project, then, appear to be shaped by its role as the legally designated agency to receive reports of elder abuse. It is seen as having a certain amount of "clout" that can occasionally be helpful in resolving a case. The Project is aided by other agencies extensively in both the investigation and intervention stages, and delegates responsibility whenever possible. It does not characteristically carry clients over the long term, but relies on other agencies for this. The Project will only be contacted if abuse becomes a major problem again.

Case Example. Mary, a woman in her late seventies who was in in the early stages of Alzheimer's Disease lived with her son Joe and his wife Sally. Although the arrangement had been fairly free of problems, Mary's other son Fred wished to assume caregiving responsibilities, and Joe acceeded to his wishes. Fred and his wife Louise were not good caretakers however. Mary was moved to a small room in the basement, and was cut off from interaction with Fred's family. She was lonely and frightened.

Mary attended a day care center, where she described the problems in her home. The day care staff contacted a local senior center, which in turn contacted the Elder Abuse Project. The Project social worker learned that Mary was receiving home health care, and contacted the supervising nurse who was familiar with the case. A meeting was set up between the Project worker, the home health nurse, a nurse from the day care center, and the director of the senior center.

As these individuals compared notes, they rapidly came to the conclusion that, as the Project social worker stated, "something funny was going on." They decided that the woman was in danger, in particular because she couldn't get out in case of fire. In addition, they felt the situation was psychologically damaging, as evidenced by Mary's occasional reluctance to leave the van when she came home from the day care center. Finally, one of the home health aides who worked with the case reported to the nurse that Mary had been pushed by the daughter-in-law.

The strategy decided upon at this meeting was to relocate Mary to a nursing home. The Project social worker met with Joe and Sally, who agreed that a nursing home would be the best option. The worker attempted to help them deal with guilt feelings about this decision. A home visit was never made by the social worker, who felt it would "disrupt the family system." Instead, she met with Mary at the day care center. This process of meeting with relevant parties took approximately five weeks, after which all parties - including Fred and Louise - agreed on a nursing home placement. After placement, EAP staff continued to follow-up on the client for a time.

In broad outline, this case shows some basic features of the Model. It has a primarily short-term focus, and relies on other agencies to provide direct services and monitor the case. The role of the Elder Abuse Project is to act as a catalyst for action, and to remain in the picture until the abuse situation is alleviated.

Client Pathway Model. Cases come in to the Rhode Island DEA through the I and R unit, which conducts a preliminary screening of the case. If the I and R worker suspects abuse or neglect, it is referred to the abuse unit. The Project Director determines how urgently the case must be dealt with, and passes it on to the social worker. After an initial assessment, a decision is made as to whether the Abuse Project should manage the case; as the Pathway Model shows (see Figure 7), questions of cooperativeness and competency of the client come into play here. Regardless of which agency takes primary responsibility, Project staff monitor the progress of each case until it is resolved. (See Figure 8 for graphic representation of Model Project services).

B. Staff Activities

In the previous section, the major features of each model have been outlined. Here, the description of the projects continues by focusing on the day-to-day activities of the workers. This information was obtained from a) the Organizational Assessment (OA) form which asked each staff person the following question:

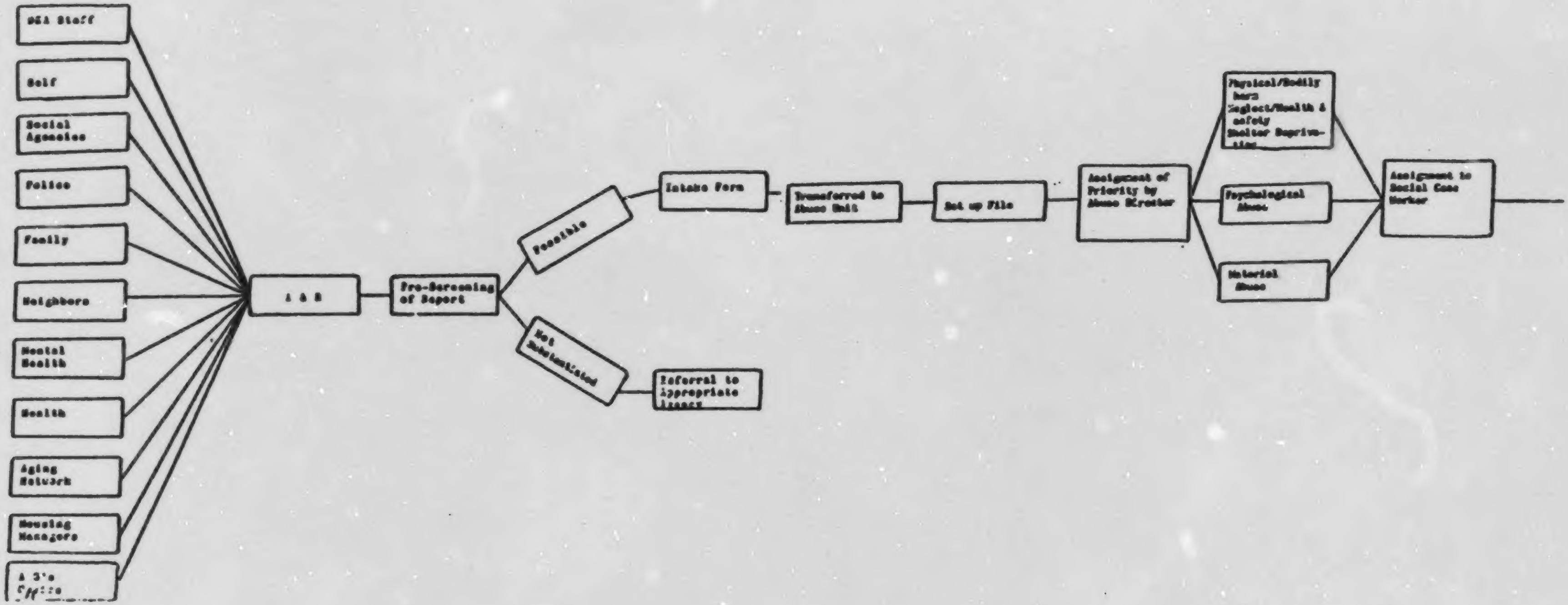
> We would like to know the specific tasks and work activities that make up your job. Please describe below the types of work activities you have been performing regularly during the past three months.

and b) the time analysis described previously. Findings from these two sources are reported in this section.

Major Activities

The Massachusetts Project Director reported that his most time-consuming activity is providing direct services to clients. This involves "visits, telephone calls, contacts with internal supports, and dealing with administrative, legal, and medical entities on the clients'

Figure 7 Client Pathway - Rhode Island


DSA Staff
Self
Social Agencies
Police
Family
Neighbors
Mental Health
Health
Aging Network
Housing Managers
A G's Office
I & R
Pre-Screening of Report
Feasible
Not Substantiated
Intake Form
Referral to Appropriate Agency
Transferred to Abuse Unit
Set up File
Assignment of Priority by Abuse Director
Physical/Bodily harm Neglect/Health & safety Shelter Deprivation
Psychological Abuse
Material Abuse
Assignment to Social Case Worker

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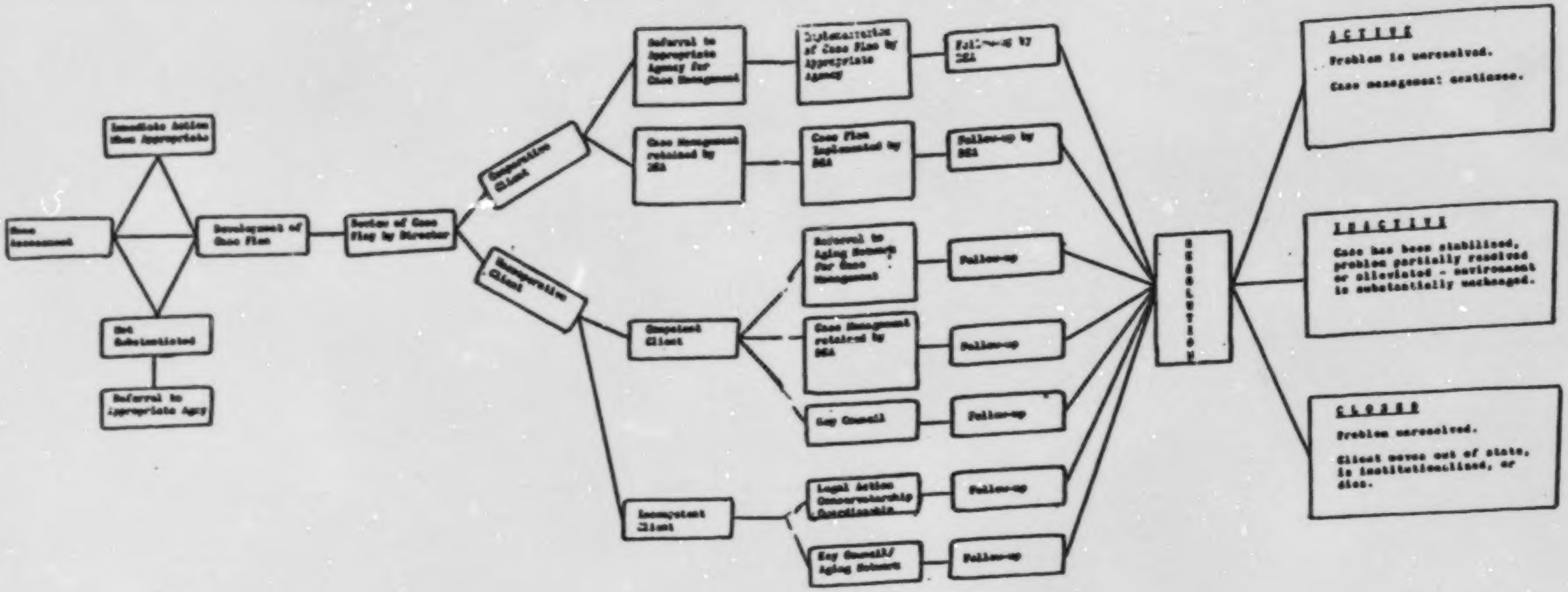

Figure 7 Client Pathway - Rhode Island (cont.)

Case Assessment
Immediate Action When Appropriate
Not Substantiated
Referral to Appropriate Agcy
Development of Case Plan
Review of Case Plan by Director
Cooperative Client
Uncooperative Client
Referral to Appropriate Agency for Case Management
Implementation of Case Plan by Appropriate Agency
Follow-up by DEA
Case Management retained by DEA
Case Plan Implemented by DEA
Follow-up by DEA
Competent Client
Referral to Aging Network for Case Management
Follow-up
Case Management retained by DEA
Follow-up
Key Council
Follow-up
Incompetent Client
Legal Action Conservatorship Guardianship
Follow-up
Key Council/ Aging Network
Follow-up
RESOLUTION
ACTIVE
Problem is unresolved.
Case management continues.
INACTIVE
Case has been stabilized, problem partially resolved or alleviated - environment is substantially unchanged.
CLOSED
Problem unresolved.
Client moves out of state, is institutionalized, or dies.

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behalf." Another important task is case recording: correspondence, case assessments, monthly reports, and the like. Other tasks include providing training to groups on protective services; receiving training through agency in-services and community programs; staff meetings; and participating is a task force attempting to implement new mandatory reporting legislation.

The social worker on the Massachusetts Project identified her major activities as home visits; contact with other agencies around referrals and case coordination; case recording and correspondence, and filling out the case assessments and reassessments required for the Project evaluation. Other tasks were giving and receiving supervision and training; making telephone calls to monitor clients, and miscellaneous paperwork.

The New York Project Director listed administration as her major activity, including program planning, development, and implementation, staff meetings, staffing the Project advisory committee, acting as a liaison to other agencies, and fulfilling Project contract obligations. Budget development and fundraising is another important task, as is direct service to clients. Other activities include supervising the Model Project coordinator, conducting community education and training, and data collection. The coordinator pinpointed two activities as those which consume the majority of her time: telephone contacts with clients and agencies to coordinate services, and conducting team meetings, case conferences, and home visits. Other tasks include screening and referral, staff development, supervision with Project Director, case correspondence and recording and filling out case assessments and reassessments.

In Rhode Island, the Project Director reported the following major activities: relations with other agencies (coordinating, technical assistance, and consultation); direct client contact; and project administration. Other tasks involved training and education, supervision of the social worker, staff meetings, and doing assessments and reassessments. The Rhode Island social worker devotes the majority of her time to "case work:" counseling clients and families, coordinating appropriate services, following up on cases, and investigating reports or abuse paperwork, staff meetings, and receiving supervision are other major tasks.

The outline of the division of labor between directors and social workers is fairly clear from these descriptions although both perform a certain amount of direct service, it is primarily the role of the social worker. Project management and extra-agency contact are left largely to the director. Further, the major activities of all staff between the three Model Projects are broadly similar.

Time Analysis

In order to obtain a more complete picture of staff organization of time, Model Project personnel were asked to complete daily time sheets for the month of February, 1983. Activities were divided into two general types: client-related, which included screening, referral, interviews, case conferences and the like; and non-client related, which encompassed such activities as Project administration, staff meetings, providing and receiving training, and others. These timesheets were added up, and a composite picture for each month was developed.

Table 7.1 compares the amount of time spent in major activities by each of the three projects. The total number of hours worked by the staff members differs due to vacations, sick days, and so forth. The breakdown of time between social workers and directors is broadly similar, in that social workers devoted considerably more time to client-related services than did the project directors. As would be expected, the Project directors devoted more time to agency relations, staff meetings, and Project administration.

Some interesting differences were found, however, between the three Projects. The social worker in Worcester spent a considerably greater percentage of her time in client interviews/homevisits than did the workers in the other two projects. This is probably due to the case management model, which required periodic in-person assessment and monitoring. The Worcester social worker spent less time than the other two projects in case recording/ correspondence, probably because the Worcester agency served fewer total clients during the course of the demonstration. Thus, the time analysis supports the notion of the Worcester Project as involving a more intense involvement with fewer cases than the other two.

The Rhode Island social workers spent substantially more time on agency contact, outreach/casefinding, and case recording/correspondence than did workers in Worcester or Syracuse. The first two categories are indicative of the mandatory reporting model. Outreach is mandated by the law, and the resulting large volume of cases, as noted before, cannot be handled by the resources of the reporting agency alone. The higher proportion of time spent in case recording/correspondence is clearly the result of the larger volume of cases and the need for inter-agency contact.

Turning to the directors, the most interesting finding is the amount of client-related services they provided. The Rhode Island director spent over half of her time on client-related tasks (53.3 percent) in comparison to 45.8 percent and 28.1 percent for the Worcester and Syracuse directors, respectively. This was necessitated, according to the Project Director, by the high volume of reports. In contrast, both the Syracuse social worker and director spent more time than the other staff in other projects on non-client related service. This is in part due to the demands of supervising and arranging for elder abuse aides, and possibly to the need to coordinate activities with the Metropolitan Commission on Aging. It is not clear, however, why there is the much greater emphasis on administration in the Syracuse Project.

TABLE 7.1 TIME USE BY MODEL PROJECT STAFF

	Worcester		Syracuse		Rhode Island	
	Director	Social Worker	Director	Social Worker	Director	Social Worker
Total hours	153.0	140.0	142.9	137.3	82.5	118.6
	%	%	%	%	%	%
a) Client related services						
Screening/referral	2.3	3.9	0.8	4.2	4.2	2.5
Client interview/home visit	11.8	26.9	8.2	5.8	-	5.4
Telephone-client	2.9	5.0	2.6	5.5	7.3	7.6
Agency contact	16.3	8.6	2.2	8.4	19.4	15.6
Supervision/consultation	0.3	2.9	6.3	7.1	3.6	7.0
Case conference	-	-	1.8	2.9	18.2	3.0
Case recording/correspondence	5.2	7.1	1.2	9.1	.6	16.0
Assessment/reassessment	2.6	0.4	1.4	10.9	-	2.5
Travel	4.6	12.9	3.8	-	-	6.3
Other	-	2.1	-	.2	-	4.7
TOTAL	46.0	72.5	28.1	54.1	53.3	70.6
b) Non-client related service						
Outreach/case finding	-	-	3.1	1.6	-	0.8
Training/education	5.9	4.6	7.2	2.9	7.9	11.8
Agency relations	3.9	1.4	9.5	7.8	15.2	1.5
Staff meetings	12.1	4.6	7.0	6.9	10.9	5.1
Project administration	19.0	10.7	32.5	20.4	7.9	5.9
Travel	8.8	2.5	7.0	4.4	4.9	2.9
Other	4.2	3.6	5.6	1.8	-	1.7
TOTAL	53.9	27.5	71.9	45.9	46.7	29.5

Without engaging in a lengthier analysis of these data, it is obvious that the time structure of activities on the Projects conforms to a degree to their organizational structure. Considerable overlap exists between the duties of social worker and director; in any intervention program of this small size, such shared responsibility for administration and direct service is probably necessary.

C. Staff Satisfaction

As noted above, one component of the Organizational Analysis was the administration of a short, standardized instrument to Model Project staff. This section reports on some of the items relating to staff satisfaction with their jobs. This is a highly important issue, as protective service programs cannot operate successfully without satisfied, committed staff. The nature of the work is sufficiently stressful that a discontented or alienated worker would be unlikely to last long in the position.

Because the total number of respondents is so small (one director and one social worker at each site) the information will not be analyzed by site. Instead, selected indicators of job satisfaction will be examined. The question of greatest importance in this context is: Does the stressful nature of work with abused and neglected elders make worker satisfaction impossible? As the following results show, the answer appears to be negative: staff reported high levels of job satisfaction, inspite of stress.

As Table 7.2 shows, all but one worker felt that their workload was hard to keep up with. In other interviews, staff repeatedly emphasized the pressures on their time, and the need at times to pay less attention to a client than they would like. For example, when asked to describe the major weaknesses of the program, one worker cited "lack of time, so that [somethings] are always behind schedule." Another felt that "the unit is too small to accomplish all the tasks assigned," and that "more time [is needed] to set goals and review progress."

In spite of this pressure, however, staff identified strongly with their work, and derived much satisfaction from it. They reported considerable autonomy in setting day-to-day tasks; were either "quite" or "very satisfied" with the job; and either put "quite a bit" or "very much effort" into the work. Further, the workers were almost uniformly likely to care very much about the work getting done right; to have their self-opinion affected by job performance; to feel a sense of personal accomplishment on the job; and to rarely think of quitting the job.

While comparative figures for other occupations are not obtainable, it seems justifiable to assert that the workers found their jobs highly satisfying and involving. This is reflected in the fact that four out of the six persons interviewed have remained on the job after the end of the federal funding, and that one of the two who left did so only because funds were cut. These findings have positive implications for

TABLE 7.2 MODEL PROJECT STAFF' SATISFACTION WITH JOB

	Responses from the six Model Project staff members
a) How heavy was the workload in the past 3 months?	
Ofen not enough to keep me busy	-
Sometimes not enough to keep me busy	-
Just about the right amount	1
Hard to keep up with	5
Entirely too much for me to handle	-
b) How much authority do you have in determining what tasks you will perform from day to day?	
None	-
A little	-
Some	-
Quite a bit	1
Very much	5
c) How satisfied are you with your job?	
Very unsatisfied	-
Quite unsatisfied	-
Somewhat satisfied	-
Quite satisfied	2
Very satisfied	4
d) How much effort do you put into your work?	
None	-
A little	-
Quite a bit	2
Very much	4

TABLE 7.2 MODEL PROJECT STAFF SATISFACTION WITH JOB (cont.)

	Responses from the six Model Project staff members
e) It's hard, on this job, for me to care very much about whether or not the work gets done right.	
Disagree strongly	6
Disagree somewhat	-
Neutral	-
Agree somewhat	-
Agree strongly	-
f) My opinion of myself goes up when I do this job well.	
Disagree strongly	-
Disagree somewhat	-
Neutral	-
Agree somewhat	1
Agree strongly	5
g) I feel a great sense of personal accomplishment when I do this job well.	
Disagree strongly	-
Disagree somewhat	-
Neutral	-
Agree somewhat	-
Agree strongly	6
h) I frequently think of quitting this job.	
Disagree strongly	4
Disagree somewhat	1
Neutral	1
Agree somewhat	-
Agree strongly	-

protective services planning: it is clear that staff satisfaction can be maintained in spite of a heavy workload.

D. Implementation

A major goal of this analysis is to determine the extent to which these three models are replicable. That is, it attempts to answer the question: How difficult would it be for another agency to implement any of the three models? Of critical importance in answering that question is the history of each Project. It would be useful, for example, to understand the historical factors that influenced the development of each program, the implementation problems that were encountered, and the way in which such problems were overcome. In this section, each Model Project site will be taken in turn, and the implementation process reviewed.

Worcester

The Worcester Model Project, as noted above, is located in a Home Care Corporation, Elder Home Care Services of Worcester, Inc. (EHCSW) that serves over 2,100 elderly persons in the City of Worcester and fifteen surrounding towns. In the late 1970's, the agency began to encounter crisis and emergency situations in growing numbers, and found that such cases involved complex legal, medical, and psychiatric issues. Case managers in the agency had neither the skills nor the time to handle such complicated problems. Other agencies in the Worcester area were simultaneously looking for new ways to deal with elders in crisis situations. In response to this perceived need, the board of directors of EHCSW decided to improve the agency's ability to respond to crises, and in general to develop greater expertise in this area. To achieve these goals, the Crisis Intervention Program was established in 1977, with the aid of a grant from Title III. A social worker with considerable experience in working with the elderly was hired, and began to assist older persons in crisis situations. She also established linkages with other providers, including legal, medical, psychological, and health services. The crisis intervention worker intervened in cases of eviction, self-neglect and abuse, maltreatment by others, and so forth.

By 1980, when the Administration on Aging solicited proposals for the Model Projects on Elder Abuse, the Worcester Crisis Intervention Program had already established itself within the community, and had gained considerable experience with elder abuse and neglect cases. It was thus perceived by persons both inside and outside the agency as a logical location for the funded project. EHCSW staff met with personnel from the Massachusetts Department of Elder Affairs, and a joint application was decided upon.

Community agency personnel interviewed in this study were in agreement that EHCSW was the logical choice for the EAP. A VNA official asserted that "Elder Home Care really has the coordinating function. They have community acceptance, and their case managers are already seeing over 2,000 cases a year. They have a broad base, a broad constituency." An EHCSW administrator highlighted the services offered by the agency:

> Because many [abuse] cases need some of our services, it's much easier just to plug them right into what we already have, so that it's easier for the crisis unit to get in a homemaker or transfer a patient or whatever: They are right here where the services are being provided.

EHCSW was viewed, then, as the most appropriate agency in the region for the project. This consensus was probably responsible for the lack of "turf" issues during the EAP's implementation; such issues were not absent in other sites. Perhaps because of its leading role in elderly services in the community, few problems were encountered with other service providers. First, since a Crisis Intervention Program already existed, other agencies were accustomed to making referrals to EHCSW. When asked what difficulties other agencies might have in implementing a project like that at EHCSW, the Project Director noted:

> I think starting from cold they's have more difficulty than we did because we inherited a situation where there was an understanding that the agency dealt with crisis cases, so all this really did was to expand our case ability. Essentially, it just added more staff. . . I think an agency starting from scratch would have to develop a reputation.

A minor problem did develop, however, as a result of the specialized nature of the Model Project. While the Crisis Intervention Program dealt with a wide variety of problems, the EAP was focused only on abuse and neglect by others. This created a situation in which the Crisis Intervention worker was assigned to cases of self-neglect or abuse, and the EAP staff handled cases in which another person could be identified as the "abuser." As the Project Director reported: "We had two different programs. . . and it wasn't clear to me for some time what my responsibilities were to the Crisis Intervention side, so there was some awkwardness some lack of coordination." After a few months, the relationship became more smooth, although an artificial distinction was maintained "between the elder abuse side and the Crisis Intervention or self-abuse, self-neglect side."

The Project Director devoted a considerable amount of time in the early months of the demonstration to agency outreach. He visited 65 to 70 different agencies and organizations, informing them about the Project, and discussing elder abuse. In those meetings, he said, "What you would be doing is kind of introducing yourself—what your training is, what your background is, what you're going to try to do, to try to inspire some confidence and hopefully generate some referrals." This process was facilitated, he added, by the receptive nature of the existing service network: "There was a good network in the community and there was a good relationship among the people who were in the network."

To summarize, then, implementation problems were very few in the Worcester EAP. The demonstration, after a small amount of initial confusion, was seen as an extension of the pre-existing Crisis Intervention Project. As the central elderly service agency in the area, EHCSW had the credibility and high profile needed to attract referrals from other agencies. Area providers were used to turning to EHCSW for case management of clients and direct service. In this respect, locating the EAP in EHCSW appeared to ease implementation problems.

Syracuse

The Syracuse application for the EAP was initiated by the Metropolitan Commission on the Aging (MCOA), the Area Agency on Aging for the Syracuse area. After some consideration, MCOA decided to approach the Alliance program at Catholic Charities, and to propose that they extend their child abuse intervention model to abused elders. MCOA staff felt that elder services in the community were sufficiently developed, but that greater coordination was needed around abuse cases. As the MCOA planner who wrote the EAP application remarked:

> We thought at the start that enough services existed in the community. What had to occur was greater coordination of services. We really weren't looking for a service provider as much as a service coordinator or service integrator. The Alliance child abuse model really seems to work.

It may seem surprising that the EAP was not located in the Adult Protective Services (APS) of the local Department of Social Services. APS has formal legal responsibility for intervening in cases of adult maltreatment. In fact, MCOA staff met with personnel at APS before writing the application. While the APS supervisors were aware of the problem, they noted that only about ten cases per year were seen by the agency, and felt that the staff might not be fully sensitive to elder abuse. This is reflected in the comments of an APS supervisor:

> We have 27 workers and get 700 referrals a month. Generally, we haven't been able to focus on elder abuse as a problem. We haven't been able to separate it out and to say that these are a group of elder abuse cases, and let's track them and monitor them and keep them separate from all the cases we've involved in. What the EAP really added was the ability to reach out to elder abuse cases as a group.

Besides the perceived strengths of the Alliance Model, and the belief that it could be applied to elder abuse, respondents also saw strengths in locating the EAP in Catholic Charities. Many who were interviewed felt that it was advantageous to have more than one place that abused elders or those concerned about them could call. One APS worker agreed:

> Welfare has a stigma, especially to the elderly. Being involved with Catholic Charities, the EAP

> gets more acceptance. We've referred cases to them for just that reason, knowing that someone in our department isn't going to be welcome.

Yet another advantage of locating the EAP in Catholic Charities was its religious affiliation. Syracuse is a heavily catholic community, and, as one respondent commented, "the elderly are heavily represented in the church-going population." Further, Catholic Charities sponsors meal sites and neighborhood centers, as well as parish outreach workers who funneled clients into the project. Thus, although there may have been mild misgivings about locating an elder abuse project in a child abuse agency (Alliance) the overarching organization of Catholic Charities counterbalanced such concerns by its wide range of elderly services.

The implementation phase of the Project went very smoothly because of the internal structure of Catholic Charities, and the connection to MCOA. Internally, there were no other workers with whom the EAP could possibly compete. Other agencies, such as the County Health Department (the major provider of home health care) and the Department of Social Services, already had strong working relationships with Alliance. Public Health nurses and APS workers were accustomed to being on teams coordinated by Alliance staff. In general, conflict did not occur with other agencies, in the words of the MCOA planner, "because elder abuse wasn't their turf." As will be apparent in the following section, relations with APS units are not always so smooth; more difficulties were experienced in Rhode Island.

As just noted, the tie to MCOA was also of great importance in ensuring the successful implementation of the EAP. Like EHCSW, MCOA is the central elderly agency in the region. It funds programs in many other agencies, and thus has a certain amount of leverage over them. MCOA convenes a regular monthly meeting of all its subcontracting agencies, at which the programs of each organization are reviewed. This provided an excellent entree for the new EAP.

In discussing the replicability of the Model Project, the Director of Alliance stated:

> The agency selected [for an elder abuse program] would have to have some clout. We had the coordination label already with hospitals and others, and Catholic Charities has a long service history. . . Any agency would have to have some drawing point and power point to get people to work with them.

By all accounts, the combination of MCOA's high community profile and Alliance's long history of coordinating other service providers gave the EAP such a "drawing point." It is likely that the success of the Syracuse project is in part due to the strength of this partnership. This is reflected in the virtual lack of serious intra- or interagency implementation problems.

Rhode Island

The Rhode Island EAP was located in the Department of Elderly Affairs (DEA) due to a convergence of factors. In a sense, DEA was in competition to a degree with the state Welfare Department (The Department of Social and Rehabilitative Services, or SRS). This agency provides adult protective services. In 1979, both DEA and SRS proposed legislation for elder protective services, and both were voted down. In the following year, however, a mandatory reporting law was passed that made DEA the designated agency to respond to reports of abuse.

During the same period, the Mental Health Coordinator of DEA had become aware of an increasing concern regarding elder abuse. In concert with the DEA director, she applied for the AOA demonstration funds, which were granted. This serendipitous turn of events placed the EAP in an unusual situation: its staff became responsible for abuse investigation under mandatory reporting.

Unlike the other two sites, consensus did not exist among respondents that DEA was the best location for the Model Project. According to one SRS worker:

> Our agency has a mechanism in place [to handle abuse]. I suspect that it's a political issue. This project could function as well in SRS. It would handle it, because the mechanism is there. For instance, it would be more geographically feasible [at SRS] than the way its operated out of here.

Other interviewees raised the possibility that the EAP could be as or more effectively located in SRS.

Some positive aspects of the DEA location were noted, however. DEA was acknowledged to have good public relations expertise, and to have mounted an effective awareness campaign among the elderly. Further, DEA, as a state agency, was perceived as having "clout" with recalciturant individuals. As a VNA nurse noted, DEA involvement is useful in "situations when families are scattered and unresponsive. When DEA goes in and calls them together, they tend to straighten up." This observation was echoed by a social worker in a senior center: "Being from DEA has clout. Just the fact that DEA is involved has changed the behavior or some family members, and made it easier for the VNA to go in, or for me to go in."

The desirability of the EAP's location is thus somewhat more ambiguous in Rhode Island. Unlike Syracuse and Worcester, the major advantage is seen as a negative one: when all else fails, DEA can go in. As will be discussed in a later section, DEA's lack of a direct service component appears to be a major factor in this attitude.

Due to mandatory reporting, DEA was spared a problem initially encountered (albeit to a relatively slight degree) in the other two sites: case-finding. The Rhode Island EAP was quickly inundated with referrals. Because of the legal sanctions against non-reporting, other agencies were only too willing to refer cases to the EAP. Perhaps for this reason, the EAP focused much of its outreach attempts not on other agencies, but on older persons themselves. A major vehicle in this effort was a series of skits on elder abuse that were performed widely to senior citizen's groups around the state.

One additional implementation difficulty is worthy of mention here. As originally planned, the Rhode Island EAP included a specialized Information and Referral (I and R) worker, who, although located in the DEA I and R unit, would handle all abuse-related referrals. This worker, in the words of the Project Director, would "do what is called 'pre-screening.' When a report came in that they felt was a possible abuse case [the I and R person] would do some preliminary screening, such as asking the caller, or doing some checking around with SRS, the VNA, or other agencies to see if the person had been to other services before. Then, that information was brought over to the Abuse Unit, and the social worker went out on it."

This arrangement quickly proved to be cumbersome, as a substantial amount of interviewing was required by whoever initially received the call, before it could be turned over to the specialized I and R worker from the EAP. Together with the director of the I and R unit, a decision was made to train all the I and R workers in abuse screening and intake, and to spread the responsibility between them. At first, there was some resistance on the part of the I and R workers to the change, especially when their normal activities were disrupted by training to handle abuse calls. Once the training was completed, however, the I and R director noted, "the work was spread out so that whenever a call comes in, whoever gets it does the intake. The resistance to the program after the responsibility got spread out has gone way down."

In conclusion, it is fair to say that none of the EAPs experienced highly serious problems in implementation. This is probably due to the following three factors:

1. The Projects were all so small (1 1/2 to 2 full-time slots) that their impact on the sponsoring agency was not very great.

2. The clients the EAPs serve - abused and neglected elders - are those that agencies generally prefer to transfer elsewhere. Elder abuse cases are usually extremely complex and often threatening; the EPAs found that other agencies were only too willing to pass on such problem situations.

3. In spite of some debate over the location of the Rhode Island EAP, all three Projects were located in highly-visible agencies which had a great deal of public acceptance and long histories of cooperation with other agencies.

On a specific level, the Rhode Island and Massachusetts EAPs experienced more implementation difficulties than did Syracuse. Other agencies had somewhat more difficulty accepting the location of the Rhode Island EAP, and problems occurred in the I and R unit. In Worcester, redundancy with the Crisis Intervention Unit, caused some confusion. The combination in Syracuse of location in a well-respected community agency, with the connection to a powerful "magnet" agency (MCOA), greatly facilitated the implementation process. While such a configuration may not be available in all locations, areas considering an elder abuse intervention project would do well to identify agencies similarly situated to the Syracuse EAP.

E. Intra-Agency Coordination

In order for an innovative project to be successful, it must establish a place for itself within the on-going operations of the agency that sponsors it. Numerous pitfalls can occur in this process: the new program may threaten other entities within the agency; it may duplicate the efforts of others; it may become ignored and isolated; or it may even become too powerful, and come to dominate agency operations in a way counterproductive to achieving the organization's primary goals. In this section, the relationship between each EAP and its "parent" agency is detailed. Areas to be examined include the utilization of the EAP by other staff, areas of collaboration with other departments, and conflict with other workers in the agency.

Worcester

A disproportionate amount of attention will be given in this section to the Worcester EAP, as issues of intra-agency coordination were of greater concern there than in the other two Projects. This is due to the specific nature of the Worcester EAP. As noted above, EHCSW employs case managers, each of whom is responsible for the assessment and monitoring of a number of elderly clients. The case manager serves as the service broker for these clients, and visits each individual once every 90 days. In addition to having official responsibility for their caseload, case managers frequently develop close personal attachments to their clients.

The EAP staff, too, were "case managers," in that they had the same responsibility for their abuse and neglect caseload: assessment, monitoring, service planning, and regular visits. Thus, there was considerable overlap of responsibility between EAP staff and case managers, which had the potential to cause conflict. In its simplest form, the issue was as follows: If a case manager reports that a client is abused or neglected, who takes charge? Does the case manager, who may have already developed a rapport with the client, continue to manage the case? Or does the EAP staff take over, because of their specialized expertise? Because of this somewhat complicated situation, the Worcester Project was forced to deal to a greater degree with intra-agency issues, while Rhode Island and Syracuse largely were not. It is therefore appropriate to focus on the challenges Worcester faced, and the solutions that were developed to meet them.

The first critical issue in intra-agency coordination at EHCSW is when a case manager ought to refer a case to the EAP. According to the Intake Services Supervisor, the original question was "when do you bring a case to [the EAP]? I think there was a period at the beginning when experienced case managers were trying to handle abuse cases on ther own. We really had to come down hard on them at some point and say if there is anything that shows any type of abuse, it has to go through [the EAP]." Thus, in theory at least, all cases of possible abuse are expected to be referred to the EAP.

The usual pattern, when abuse is suspected, is for the case manager to bring it to the attention of their supervisor, who then takes it to the EAP director. Following this action, one of three basic methods of handling the case are employed. These are as follows:

1. The abuse unit takes over the case completely. The EAP staff became the case manager, and relieve the individual who referred the case of all responsibility for it.

2. The EAP acts strictly in a consulting role, advising the case manager as needed, but not assuming the management of the case in any way. This generally occurs when abuse and neglect are highly questionable.

3. The EAP and the case manager "co-manage" the case. Under this arrangement, both parties retain a strong hand in the case, and plan the intervention jointly. This tends to occur when abuse or neglect is determined to exist, but when the case manager has already established a strong relationship with the client.

The general consensus of interviewees was that, in cases of verified abuse or neglect, the EAP tends to take over the case. In fact, difficulties were encountered when attempts were made to transfer a client back to the case manager. The EAP social worker reported that transfer is problematic.

> Ideally, cases should be transferred over to a case manager [once they are resolved]. At that point, theoretically, I shouldn't be involved. But this doesn't take place frequently... I think I've transferred one case over. . . The one that I did transfer over, it came back. It

> was an issue of financial exploitation, and the people who were the original financial exploiters left the scene. We got them out of the apartment they were renting from the client, and then she got some new people in there who proceeded to do the same thing. So, when I had given the case manager the case, everything was under control. Then it came back again.

The social worker went on to note that even if a case is more completely resolved, transfer is difficult. She stated:

> Sometimes with these cases, things are bad. Then, if they get better, the worker who's involved at that point has the advantage of having done something really concrete with the client, and having a relationship and a trust that carries a lot of weight. So it's hard to give up the case at that point. [In the case described above], I hadn't seen the woman for probably about six months, but it was fairly easy to get back into the relationship.

The case manager who worked with this client also felt confused by the transfer process. He reported:

> The case was given to me because the problems had settled down. [The EAP worker] felt that it was no longer an abuse case, and could be handled by a regular case manager. She gave it to me. Everything went along okay for a little while, and then the same problems came up again. . . I went back to [the EAP worker] with the case and we discussed it, and I said that I had essentially done everything that I could with the case, and that I needed assistance with the problems. . . About a month ago, I found out that we were co-managing the case. I didn't know [in the interim] what had happened to the case. I would rather they take it over.

A second issue that crops up in the EAP worker—case manager relationship is the question of when a case ought to be turned over to Project staff. As one supervisor asserted: "I think that people feel it is a good resource, but there is some confusion as to the definition of what kind of cases fit into what categories, and when it is appropriate for a case manager to keep it, or for it to go to the [EAP]." Case managers tended to refer clients when they reached "the end of their rope. One reported:

> I will only turn a case over when I've reached a point where I've exhausted all the contacts that I have, and all the resources that I have, and

> nothing is changing in the case, and also it becomes so time-consuming, and nothing is changing. Then I turn it over to [the EAP], when I've just run out of things that I am able to do.

A supervisor echoed this sentiment, but grounded it more firmly in the limitations of the case managers' role:

> I think there's a point where case managers really can't deal with, and aren't trained to deal with some of the dynamics that are involved with an abuse situation. They just don't have the social work skills to get the information out of the people and still have the people trust them.

In general, agency administrators have encouraged case managers to give up the complicated abuse cases, in order to have ore time for other tasks. According to the Intake Services supervisor:

> Within this past year, we've really been trying to limit the case managers to what their job is. They will go out and do information and referral, refer people to the proper places, but they're not supposed to be doing all these different kinds of jobs, and so we've been working with them very carefully to limit themselves. . . They're not supposed to really get involved in real critical crisis or abuse cases.

In actual practice, such involvement on the part of case managers occurs; considering the length of time some case managers work with their clients, it is understandable that they may see themselves as best situated to handle the crisis situation. As an administrator noted:

> Occasionally the case managers feel that [the EAP] is taking over; you know, pulling on their turf, or taking something away from them. But [the EAP staff] have made it known to case managers that if the case manager feels that he or she can be involved, and would like to continue handling a case, that they would pretty much let them do it.

In fact, case managers reported the occurrence of such an arrangement. The following account provides a good example:

> One case I referred [to the EAP] involved a man and a woman living together; the man was suspected of abusing her. Instead, it was mutual abuse. I told [the EAP worker] that I didn't

> want her taking over the case. First of all, it had taken me a long time to develop a relationship with these people. They knew me, and I knew them. They knew that I knew that there was some friction there. Introducing a stranger would be a difficult thing. [The EAP worker] seemed to think that was fine. So what she did mainly was to consult and brainstorm, and offer me some alternatives as to what I could present to the client as alternatives so she didn't manage the case. It was more on a consulting basis.

The central point of all of these examples is that intra-agency coordination was a major issue of concern in the Worcester EAP, one that required extensive attention and is still perceived as an important area for Project improvement. Further, this issue was not salient in either of the other two Projects. It appears to be due to the particular structure of EHCSW. Unlike the other EAPs, EHCSW employs workers with responsibilities that overlap substantially with Project staff; in fact, one Model Project worker is a former case manager. Because of the similarity of the tasks of EAP staff and case managers (a situation which did not exist in the other EAPs), some conflict was probably inevitable.

This tension is reflected in the fact that every respondent in EHCSW - administrators, case managers, supervisors, and EAP staff - noted that improving communication between the Project and case manager was an important on-going agency goal. Thus, the Project director observed that we may not do as good a job as we should about making everybody aware of exactly what it is we're doing." A case manager confirmed this opinion:

> The major problem that I've perceived with this project is a lack of communication. There wasn't nearly enough feedback from either of the two workers involved [in one case]. My own suggestion would be that the [EAP] workers be more open to sharing information with the case managers.

Another respondent supported the motion that some intra-agency friction could be attributed to lack of communication:

> Communication is the absolute key. [The EAP staff] just have to keep in touch with the rest of the staff so that staff knows what they are doing. I am pleased, pleased with the way it's breaking here, but I think it even could be better. I go out to other agencies, or other home cares throughout the state, and they are just dying to hear about our abuse unit and are just thrilled. And [the Project director] will go out and talk and give speeches all over the community--I think they are more aware than our

> staff. I don't think our staff feel that sense of pride and feel a sense of how fortunate we are to have these people in our agency.

We have dwelt at such length on these internal problems not to highlight weaknesses specific to EHCSW. Rather, it is extremely likely that such difficulties will occur in any agency with a similar structure. The other two EAPs were free of such problems simply because they do not have workers similar to EHCSW case mangers. Any agency that structurally resembles EHCSW should prepare itself to encounter problems of intra-agency coordination. It is greatly to EHCSW's credit that these problems were openly recognized and discussed. The EAP staff were very open to criticism in this area, and attempted to overcome it. For example, over the course of the project, more formalized methods for referral of cases to the EAP were developed. At the time of the interviews, staff in-services were being planned, and a number of other options to increase communication were under consideration. It is particularly important to note that all interviewees were in general highly satisfied with the EAP, and felt it had had a positive impact on the agency. Improvements in communication were seen as ways of further improving the EAP.

On a final note, individuals planning elder protective services must realize that the structure of a particular intervention program can bring strengths in some areas, and weaknesses in others although the Worcester EAP encountered some difficulties in intra-agency coordination, its relationship with other agencies was extremely smooth and problem-free; more so than at either of the other EAPs, as will be discussed in Section F.

Rhode Island and Syracuse

The other two EAPs are included in a single section for one reason: virtually no difficulties in intra-agency coordination were uncovered in either site. Unlike EHCSW, there was little overlap of responsibility with other workers in these Projects. In Syracuse, in particular, the only comments received from Catholic Charities staff were extremely positive. As one worker put it: "The project has been very well accepted within this agency." The Syracuse EAP did not cause any "turf" problems for other workers; the latter freely referred cases to them. These other workers included parish out-reach workers, nutrition site case workers, and other individuals who did not have an on-going client caseload. Referral to the EAP did not cause them to "lose" a client.

The same held true in Rhode Island: other agency staff worked in such different areas that coordination problems around cases did not surface. Two intra-agency difficulties did occur in Rhode Island, however. The first has already been described: the evolution of the relationship with the I and R unit. The second problem involved the split in the Project director's responsibilities. The director was half-time on the abuse project, and half-time as the Mental Health Coordinator for DEA. Due to the extremely high number of referrals, the pressures of mandatory reporting, and the departure mid-project of the social worker, the Rhode Island director became burdened with a large abuse caseload.

This caused conflict with her other duties. If the Rhode Island model is to be replicated elsewhere, it appears preferrable to make the director position a full-time one.

F. Interagency Coordination

In recent years, an intense interest has developed in interagency coordination. Case management programs are springing up in many human services fields. In long-term care, the Channeling Demonstration Project is devoted to fostering coordination of health and social services. Van de Ven and Ferry (1980) suggest one major reason for this interest:

> Many complex social and economic problems require joint inter-organizational planning and programming because the requisite resources, expertise, and motivation are contained within autonomous organizations and vested interest groups. Thus, organizations must increasingly establish coordinated relation-ships with other agencies, creating, in effect, organizations of organizations.

Such interagency coordination is especially important in cases of elder abuse/neglect. While the precise extent of abuse and neglect of the elderly is not known, it is clear that such cases are often extremely complex and difficult. They generally require the involvement of a number of social service, health, and/or legal agencies before they are resolved. A critical question for our organizational analysis is therefore: How does interagecy coordination take place?

In this section, the way in which such coordination was carried out by the three EAPs is explored. As the ensuing analysis will demonstrate, the pattern of exchanges with other agencies varied to a certain extent according to the structure of each Project. The amount of services directly provided by the EAP, for example, had an impact on how much coordination was necessary for the operation of the Project. Similarly, the willingness of other agencies to cooperate with the EAP was related to what they felt the Project staff had to offer them. In order to understand interagency interaction, two types of data were employed: interviews with staff in the EAPs and other agencies, and results from the Organizational Assessment Instrument (OAI).

For the OAI analysis, each EAP was asked to identify the most important agencies with whom it had had to coordinate during the previous six months. Rhode Island and Worcester identified five such agencies, and Syracuse four. Figure 8 shows the agencies selected:

Figure 8 Agencies Identified by EAP Staff as Most Important for Interagency Coordination

Worcester	Rhode Island	Syracuse
Visiting Nurse Association	Visiting Nurse Association	Public Health Nursing
Legal Services Corporation	Police Department	Information and Referral Service
Elderly Outreach Program of a Neighborhood Center	Senior Center	Elderly Services in Family Outreach Center
Geriatric Psychological and Counseling Services	Mental Health Center	Adult Protective Unit
Geriatric Aide Program in Jewish Family Services	Welfare Department: Adult Protective Services	

There are some obvious similarities and differences in these choices. All three EAPs selected a home health agency and a senior or neighborhood center. Both Syracuse and Rhode Island named Adult Protective Services, which are not available in Massachusetts. Rhode Island and Worcester identified as important a psychological counseling service, while Syracuse did not. Finally, each EAP had one unique choice: Rhode Island named the police department, Syracuse an information and referral hotline, and Worcester a Legal Services Corporation. Thus, while coordination with certain agencies appears to be important across sites, specific program factors or historical relationships may influence reliance on other particular agencies, as well.

Turning now to the specific EAPs, the differences in interagency interaction become even more apparent. These differences lie in the areas of the strength of the Project's case management role; the amount and quality of formal and informal coordination, and the satisfaction of other agencies with their contact with the EAP. In order to understand these differences, the interview data on each site will be taken in turn. Following this analysis, the OAI data for the three sites will be compared and discussed.

Worcester

It is important to review at the outset the nature of the Worcester EAP. It is, as noted earlier, located in the central elderly service agency in the region, one which has long been looked to for leadership in a variety of areas. Further, as case managers, the Worcester EAP staff were able to personally authorize a wide variety of services for their clients, including homemaker, chore, transportation, and nutrition services. This combination of organizational prestige and control over resources made the EAP staff likely to take coordinative responsibility for a case.

The Worcester EAP social worker described a typical example of case coordination which shows her central case managemment role:

> This was a man living with his daughter. I used the Age Center initially to find an appropriate companion for him. Then, I called an adult day health center. I spoke with a social worker there, described the situation and asked if she felt the person was basically appropriate, and what would need to be done to get him accepted there, and got some information from them regarding the program. Then I spoke with our visiting nurse liaison about the situation. I told her I wasn't really clear on the medical background: "I'm getting some fuzzy stuff, so would it be possible for you to make a visit?" [So, in this case] I had been real specific about what I wanted - what I needed.

In this case, the EAP worker was firmly in charge, and directing services provided by other agencies. When the social worker was asked who would be likely to manage a case, she reinforced the example given above: "sometimes it seems like it's fifty-fifty, but I think that more likely it would be ourselves as opposed to another agency." When asked the same question, the EAP director confirmed this statement: "I think we would be seen as the continuity, that we would be the ones who were there all the time and who had the information on the situation."

In terms of formal coordination, Worcester EAP staff did not mention the existence of written agreements with other agencies. One formal mechanism was employed, however: a Crisis Intervention Task Force. This Task Force involved fifteen agencies that met to advise the EAP. It met originally once a month, but this, according to the EAP director, was found to be too frequent. In general, EAP and other agency staff minimized the importance of this Task Force in on-going case coordination.

The Worcester EAP was also not likely to call formal case conferences. The social worker reported: "We have had case conferences...but that is not usual. Ordinarily, we just conference back and forth on the phone." The director supported this, acting that "most of it is ad hoc... much of it is on the telephone." This is again probably characteristic of the resources the Worcester EAP has at its disposal; with a few exceptions (e.g., home health care) EAP staff can offer a host of services on their own. Interagency coordination can therefore take place on a more "ad hoc" basis than in the other two Projects.

In general, the EAP reported few conflicts with other agencies. Staff noted occasional difficulties with legal services; in particular, access to the legal staff was sometimes difficult. More serious problems were encountered with the Emergency Mental Health unit to which psychiatric cases are brought and evaluated. These persons are then either referred elsewhere for treatment or institutionalized. EAP staff reported that they had brought in clients they clearly felt should be institutionalized and were rebuffed. Frequently, they asserted, these clients would end up in the state hospital shortly thereafter, through other more dramatic routes.

Syracuse

The Syracuse EAP paid the most extensive attention to issues of interagency coordination; in fact, the Project was designed as a coordination model. As noted above, the EAP was based on the assumption that a sufficient quantity and variety of elderly services existed in the region, and that what was needed was greater coordination. The Syracuse Project was the only one that established a formal structure for coordination: the "team meeting." Coordinative issues were thus of central concern to this EAP.

First, it is important to note that the EAP took advantage of numerous formal opportunities for interaction with other agencies. MCOA holds regular monthly meetings with all of their contracting agencies, of which agency programs and service needs are discussed. The agencies involved include an Information and Referral Service, transportation providers, respite care programs, shared housing sites, neighborhood advisor, and others. As one participant described it, "This is an informal way of having everybody know what everybody else is doing." The EAP director echoed this sentiment: "MCOA has a well-organized service system of its own, so there was an immediate, on-going vehicle for us to plug into." As in Worcester, the Project Director conducted extensive outreach to other agencies at the beginning of the grant. An advisory committee was established early on, and the agencies represented agreed to refer cases to the EAP. Further, the Director reported, "I went around and talked with people, both administration and line staff. I would ask them to tell me about cases. Then [we] began to intervene in some cases."

Turf issues did not develop with other agencies. The Director related that "working with community organizations, like senior center, I and R, and housing, wasn't a problem. Elder Abuse isn't their turf." She raised a very important issue, however, which could have been a major stumbling block for the program: "the Adult Protective Unit in DSS could have been a problem. DSS is giving up some power, by allowing us to step in on their turf." As in Rhode Island, the potential for conflict exists, for an answer must be found to the question: What does a specialized elder abuse program offer that Adult Protective Services does not? If the APS unit did not accept the EAP, and - as in Syracuse's case - no law exits that required reporting, the operation of the Project would be very difficult.

In fact, the relationship between APS and the EAP appears to be excellent. In part, this may be due to the concerted attempt that was made to involve APS staff in planning for the EAP at the beginning of the Project. It is also partially the result of a history of APS-Alliance collaboration on child abuse cases. Primarily, however, the success of the relationship with APS (and other agencies) lies in the flexibility of the approach of the EAP, and in the willingness of the staff to adopt different roles depending on the case. It is important to recall that the Syracuse EAP has neither the legal mandate of the Rhode Island Project, nor the attractive direct services to offer of the Worcester Project. In order to secure the cooperation of other agencies, Project staff had to fill a role that served other agencies, while not antagonizing them.

The success of this approach is evident from the interviews with APS staff. First, one APS supervisor asserted that the EAP workers had made great attempts to get to know the front-line APS workers.

> Probably just about every supervisor and worker [in this agency] has at one time had some case in common with [the EAP staff]. When they walk in everybody knows who they are, and they seem to know all of our people by name. So it's not only on an official, impersonal basis, but we know them and they know us, and if we want to share information or pick their brains, we're not above calling them, and certainly they're not above calling us.

Further, the APS staff saw the need for specialized workers with expertise in elder abuse:

> We have twenty-two workers and get 700 referrals a month. Generally, we haven't been able to focus on elder abuse as a problem. We haven't been able to devote the kind of time to separate it out, and to say that these are a group of elder abuse cases, and let's track them and keep them separate from all the other cases we're involved in. What the EAP has really added is the ability to track abuse cases as a group.

Finally, APS staff use the EAP because of the special training of the workers themselves:

> Both [EAP workers] have extensive backgrounds, and we look to them as people who are into a very specialized area, and who have some competence and proficiency. They know their way around pretty good. And in the cases we carry cooperatively, it gives us a good feeling that we're not in their alone. We can check out our perceptions and share our ideas. All in all,

> it's nice to have another agency in there working with you. Sometimes by carrying out specific work roles on that case, you get things done that we probably wouldn't otherwise.

Thus, the major potential conflict was defused through mutual acceptance and coordinated planning. Without providing additional examples, other agencies uniformly supported this view of this EAP. In fact, the EAP was actually able on occasion to defuse conflict between other agencies; they stepped in, for example, on a disagreement between APS and Public Health Nursing and helped resolve it.

One major reason for the positive response towards the EAP on the part of other agencies is its great degree of flexibility with regard to case management. In theory, the EAP was expected to play a primary management role, as the Project was based on coordination. For every client, a "team" was established, which usually involved at a minimum a Public Health Nurse and Adult Protective Services worker. Occasionally, this team meets formally to review the progress of the case, in the same manner that Alliance child abuse cases do. However, the EAP staff in actual practice adopt a wide range of case management styles, from assuming direct responsibility for the case to acting as an occasional consultant.

This flexibility is evident in the area of referrals. The EAP Director reported that APS and the EAP "work side by side. People can call where they feel the most comfortable." An APS supervisor echoed this sentiment:

> Perhaps it was important with the Health Department that they have two places they could send a referral, and if they didn't think we were moving with the speed they wanted, or in the direction they wanted, they could probably say "well damn them, I'm going to send this over to Elder Abuse."

Similarly, the on-going management of elder abuse cases is highly flexible; so much so, that respondennts even had a little difficulty identifying who is most likely to have ultimate responsibility. As the EAP director described the process:

> I guess we get a referral and go out on it, often with a Pro-tective Service worker, sometimes alone, sometimes with someone else, and make an assessment and be responsible for sitting down at a meeting, trying to work out who's going to do what; and who's going to sell the family on this plan. Then we make some attempt to keep on track. If there is an APS worker that has a relationship and can continue to stay involved, we really would not seek much direct contact.

> Ideally, the way [the coordination role] would go would be to go in on the assessment process, have a direct hands-on and a chance to observe and form an opinion, and then [all the agencies involved] would share that and come to some agreement with help from DSS as to what our roles would be. Then from time to time we would convene things... but some of that wasn't done in a meeting. We don't follow as formal a structure as the Alliance Child Abuse teams. We might be more likely to get on the phone. If there seems to be some reason to get protective Services and Public Health Nursing and ourselves back together for a sit-down, we would.

Two additional examples will make this point even clearer. An administrator in Public Health Nursing asserted that the issue of who takes on the case management role may actually depend on who encounters the case first:

> [Coordination] depends upon the case, what has happened, and who sees the need at that point in time. If the nurse goes in and sees something going on, she may contact everybody else... if the others went in and they saw something, they could coordinate. It was left in our agreements basically that any group could coordinate at any given time. That role may shift and change; for example, there may come a point where we're no longer providing a service, but the other two agencies are still involved.

And a senior center worker related the case management responsibility to the nature of the abused individual's primary difficulty:

> I think it depends on what the problem is. I think if its more of a health-related problem, then the Health Department would be the one that would be spearheading a meeting [for coordination]. If its primarily an abuse problem, then the EAP would most likely coordinate.

It is apparent from comments such as these that coordinating role of the EAP is allowed to vary according to a number of factors: the primary nature of the problem, who first discovers the case, and so on. In this way, it is unlike the Worcester EAP, which generally assumes fairly complete case management responsibility for its clients. The Worcester EAP staff have such strong control over services that they become the logical coordinator for other agencies involved in the case. Syracuse staff may technically coordinate (e.g., they may call a team meeting) but on-going, day-to-day monitoring is as likely as not to be carried out by another agency.

In summary, the Syracuse EAP was not found to have had any serious problems in interagency coordination. The interviews show a great appreciation for the Project on the part of other agencies. They also demonstrate a high degree of flexibility on the part of Project staff as to the way in which responsibility is shared around cases. Formal and informal mechanisms of coordination appear to have been firmly established, and to be functioning smoothly.

Rhode Island

Rhode Island, like the other two EAPs, employed both formal and informal mechanisms of coordination. A major formal entity were the "key councils" established by the Rhode Island DEA a number of years ago. These are interagency groups of service providers that meet at regular intervals. A special subcommittee of the Providence Key Council was established to work specifically with the EAP. Rhode Island staff also conducted information sessions with area agencies, although, as noted above, most of the outreach was targeted toward elderly people themselves. Further, DEA offers concrete support to Rhode Island's aging network: it awards over 50 grants a year to move than 30 different organizations for the provision of services to older person. A grants management staff maintains monthly contact with these grantee agencies.

Based on the interviews, the Rhode Island EAP appeared to have more difficulties in interagency coordination than did the other two EAPs. Other agencies were more likely to express dissatisfaction with the coordinative process, and to see a need for mechanisms that would make interagency interaction smoother. It is of great importance to this analysis to note that the reasons behind such problems in coordination lie in the basic structure of the model. As such, they have critical implications for the replicability of the Rhode Island Model.

As described above, the Rhode Island EAP has two noteworthy facets. First, it is the only EAP that operated under the constraints of mandatory reporting. As such, it received more referrals than the other Projects; many more, in fact, than could have been successfully case-managed by the Project staff. Therefore, an attempt was made to transfer control of cases to other agencies as quickly as possible. Second, unlike Worcester and Syracuse which had concrete services to offer, Worcester, a wide range of home care services, and Syracuse has specialized case aides, the Rhode Island EAP had to rely on other agencies for help, in exchange for which, because of time constraints, they had less to offer in return.

Other agencies reported that they usually contacted DEA because the law required them to do so. But they generally recognize that it is difficult for EAP staff to involve themselves extensively in any individual case. As one interviewee noted:

> [The EAP staff] have taken on a lot. They have to cover a large geographical area. They are doing a lot of running around, and I wonder if it isn't a situation that's brought on just by the structure, the nature of the program.
>
> The law puts them in a difficult situation, because while it mandates that they investigate certain types of abuse and neglect... and provide services, there are just not enough services out there for them to resolve situations quickly.

A staff person from another agency also highlighted the constraints on the time of the EAP staff: "when they weren't too busy, they wanted to be in charge of cases. When they got busy, they wanted to push cases over to community agencies."

As might be inferred from these comments, the EAP was considered by many agencies to be unlikely to take on direct management of a case. Referrals were made to comply with the law, and occasionally the "clout" of the state agency would be employed, but on the whole, other agencies would attempt to stay in charge. An Adult Protective Services worker reported:

> If we have a case they've seen, but decided no action is appropriate, we monitor it. If we see it approaching a crisis state, we call DEA and say we think the case is going to blow. We see them as having mandate and having the authority to do something, and want them to know what's going on. But a lot of the day-to-day stuff we do ourselves. DEA couldn't do the day-to-day stuff because of staffing.

When asked if the EAP had changed her agency's way of handling abuse cases, she went on:

> No, [before the EAP] we would handle it in the same way, except we wouldn't call in, and we wouldn't have another agency to work with...our procedure hasn't changed at all.

Thus, the design of the Project caused it to give responsibility for cases to other agencies, and to rely on them for help in managing the case. However, as the second part of this section will show, other agencies perceived the EAP as having little to offer in return in the way of needed direct services. It also is unable to take problem cases off other agencies' hands in a permanent way, unlike the Worcester EAP. For this reason, a more or less imbalanced exchange exists between the EAP and other agencies. This was evident even when the interviewee expressed overall satisfaction with the EAP. For example, a social worker from a senior center who in general spoke highly of the project noted that of the four times he had made joint visits with the EAP, he had never initiated the contact; they had called him for help.

One additional comment is necessary regarding interagency coordination in Rhode Island. Such coordination is more critical to this EAP than for Syracuse or Worcester, due to the nature of the model. Worcester controls many services in its own agency, and Syracuse provides the attractive aide service. The Rhode Island is not seen as offering anything like this, so, in order to succeed, it must maintain productive relationships with other agencies. Instead, an imbalance of exchange was found. One major way of remedying this imbalance would be in the inclusion of a direct services component in the Rhode Island EAP, that is, a service that Project staff could personally authorize. agencies. The problem appears to be one of lack of resources; the establishment of a Syracuse-type aide program could be a first step in such an effort. Other steps taken by DEA are noted below.

Further, a de-centralization of the program into local agencies appears adviseable. The staff were too severely taxed by the sheer number of very serious referrals. Trained workers could be placed in local agencies under the general supervision of the EAP. Previous research has shown the need for specialized abuse workers, which would recommend against shifting investigative responsibility to regular community agency staff. If some agencies could employ part- or full-time workers to intervene in cases after they were reported to the EAP, a more comprehensive response would become possible.*

Findings From Organizational Assessment Instrument

In order to explore interagency coordination in a more quantitative way, the agencies identified by each EAP as its primary contacts were given an OAI questionnaire. This instrument contained a variety of questions regarding the nature of interaction with the EAP and satisfaction with the Project. As noted above, five agencies were identified by Rhose Island and (Worcester) and four by Syracuse. Table 7.3 present results from this survey. The sample of agencies is so small that these findings cannot be considered to be definitive. However, these agencies were selected by the Project staff as representative of those they work with.

In general, this analysis uncovered broader similarities between the Worcester and Syracuse Projects than between either of those Projects and Rhode Island. In particular, other agencies were more likely to report inbalanced exchange with the Rhode island EAP. Agencies all felt that they were quite or very well acquainted with the elder abuse staff. In subsequent questions, however, differences were found. Other agencies in Rhode Island were less likely to feel that they were very well informed about the EAP; that effective working relationships

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*Such a model is currently in place in Massachusetts.

TABLE 7.3 OTHER AGENCY PERCEPTIONS OF ELDER ABUSE PROJECTS

	Worcester	Syracuse	Rhode Island
a) How well are you personally acquainted with the staff of the Elder Abuse Project?			
No personal acquaintance	-	-	-
Not very well	-	-	-
Somewhat well	-	-	-
Quite well	1	2	2
Very well	4	2	3
b) How well-informed are you about the specific goals and services of the Elder Abuse Project?			
Not at all	-	-	-
Little informed	-	-	1
Somewhat informed	-	-	1
Quite informed	1	-	1
Very well informed	4	4	2
c) Prior to the past six months, to what extent has your agency had effective working relationships with the Elder Abuse Project?			
No prior contact	-	-	-
To no extent	-	-	-
Little extent	-	-	1
Some extent	-	-	2
Considerable extent	1	2	1
Great extent	4	2	1
d) Consider how the equality of the give-and-take relationship with the Elder Abuse Project compared to other agencies that you are involved with. HOw fair do you feel are the payoffs to your agency from the Elder Abuse Project?			
We get much less than we ought.	-	-	1
We get somewhat less than we ought.	-	-	1
Balanced	5	4	3
We get somewhat more than we ought.	-	-	-
We get much more than we ought.	-	-	-

TABLE 7.3 OTHER AGENCY PERCEPTIONS OF ELDER ABUSE PROJECTS (cont.)

	Worcester	Syracuse	Rhode Island
e) For the Elder Abuse Project to accomplish its goals and responsibilities, how much does it need the services, resources or support from your agency?			
Not at all	-	-	-
Very little	-	-	-
Some	1	-	1
Quite a bit	4	2	1
Very much	-	2	4
f) Been explicitly verbalized or discussed?			
To no extent	-	-	-
Little extent	-	-	1
Some extent	1	-	3
Considerable extent	4	3	1
Great extent	-	1	-
g) Been written down in detail?			
To no extent	1	-	3
Little extent	3	1	1
Some extent	1	1	1
Considerable extent	-	2	-
Great extent	-	-	-
h) During the last six months, how often were the disagreements or disputes between people from your agency and the Elder Abuse Project?			
Not once	5	3	1
About once a month	-	1	3
About every 2 weeks	-	-	1
About once a week	-	-	-
Several times a week	-	-	-
Every day	-	-	-

TABLE 7.3 OTHER AGENCY PERCEPTIONS OF ELDER ABUSE PROJECTS (cont.)

	Worcester	Syracuse	Rhode Island
i) How well are any differences worked out at this time between your agency and the Elder Abuse Project?			
Very poorly	-	-	-
Poorly	-	-	2
Adequately	1	1	2
Quite well	1	1	-
Very well	3	2	1
j) Overall, how important was the Elder Abuse Project in attaining the goals of of your agency during the past 6 months?			
Not very important	-	-	3
Somewhat important	2	-	1
Quite important	3	1	-
Very important	-	2	1
Absolutely crucial	-	1	-
k) To what extent do you feel the relationship between your agency and the Elder Abuse Project is productive?			
To no extent	-	-	-
Little extent	-	-	-
Some extent	-	-	4
Considerable extent	1	-	-
Great extent	4	4	1
l) To what is the time and effort spent in developing and maintaining the relation ship with the Elder Abuse Project worthwhile?			
To no extent	-	-	-
Little extent	-	-	-
Some extent	-	-	4
Considerable extent	1	-	-
Great extent	4	4	1
m) Overall, to what extent are you satisfied with the relationship between your agency and the Elder Abuse Project during past 6 months?			
To no extent	-	-	-
Little extent	-	-	-
Some extent	-	-	4
Considerable extent	-	1	-
Great extent	5	3	1

existed at the EAP; and that the give-and-take relationship with the EAP was balanced. They were more likely to say that the Rhode Island EAP needed their services or support.

Worcester and Syracuse were both more apt than Rhode Island to have verbal and written understandings with other agencies; particularly, Syracuse. Rhode Island agencies reported a greater frequency of disagreements with the EAP, and were less likely to feel that such disagreements were successfully worked out. Syracuse agencies felt the most strongly that the EAP was important in attaining their goals, while Rhode Island reported this the least.

Syracuse agencies were most likely to feel the relationship with the EAP was productive and that their effort spent developing and maintaining this relationship was worthwhile. Agencies in Worcester registered the most overall satisfaction with the EAP. Rhode Island lagged behind the other two Projects in these areas. A separate research component of the overall evaluation of the three Model Projects described elsewhere in this report substantiated these findings (See Chapter Eight).

It is important to note that Rhode Island DEA staff are aware that some agencies are resistant to DEA intervention and have taken steps since the end of federal funding to overcome coordination problems. First, DEA has moved to make clear to its grantee agencies that the funding they receive is in part to cover case management of abuse cases. Contracts with senior centers and social service agencies have become more specific in this way. The relationship between the Department and its grantee agencies, DEA staff report, has been strengthened due to a clarification of DEA's expectations regarding the role of these agencies in case management for abuse victims.

Second, since January 1984, monthly meetings have been held for workers involved in abuse cases. These meetings are scheduled and conducted by DEA staff and provide an opportunity for workers to express their concerns, share their difficulties, and receive ongoing training. Sessions for this group have been held with the Attorney General's Office regarding legal issues, mental health professionals regarding commitment procedures, a legal services developer regarding probate court, and other issues. According to DEA, these sessions have proven to be very valuable, and have kept the lines of communication open between workers and DEA staff.

G. Summary and Conclusions

It has been the aim of this organizational analysis to look at the basic structure of each EAP, and to examine the impact of that structure on other aspects of the Projects, such as implementation, staff activities, intra-agency coordination, and relationships with other agencies. There were two basic purposes underlying this analysis: 1) to provide a detailed picture of the process of the three Model Projects, and to show

how they operated on a day-do-day basis, and 2) to draw some conclusions regarding the replicability of the models. The first task will be addressed in Chapter Ten. The descriptive study has been completed and will be summarized below.

At the risk of some oversimplification, the three EAPs were categorized into basic types. Worcester was termed a "service brokerage" model. It was located in an elderly service agency, and the EAP had direct control over a wide range of in-home social services that could be employed to help resolve a case. A major function of this EAP was thus to introduce and manage services. Syracuse was characterized as a "coordination" model. While all three EAPs filled a coordinating role to some degree, the Syracuse Project made this aspect the core of their efforts. Rhode Island was identified as a "mandatory reporting" model. It was the only EAP to operate under a mandatory reporting law, and was the only Project to operate out of a state agency.

The implementation of all three Model Projects was on the whole quite smooth. In all three agencies the presence of specialized elder abuse workers was seen initially as an asset to the agency. The EAPs did extensive outreach, and had little or no difficulty obtaining referrals. A few problems were encountered in intra-agency coordination. These primarily involved defining the EAP workers' roles vis-a-vis those of other worker's in the agency. In Worcester, the primary difficulty was delineating the responsibilities of the case manager and the abuse worker. The agency perceived a major advantage of having the EAP as relieving case managers of difficult clients. However, some case managers found abuse and neglect cases interesting and satisfying to work on, and were unwilling to relinquish them. This was at least partially resolved by the institution of "co-managing" the case. In such instances, the case manager remains involved, but receives advice and direction from the EAP worker. This problem of control over a case appears likely to arise in any agency in which the training and responsibilities of abuse workers overlap with those of existing agency staff. Co-management emerged as a successful strategy at the Worcester site, and deserves consideration elsewhere.

At the Syracuse project, no such overlap existed with other workers. In Rhode Island, however, it occurred on a small scale in the intake process. The Elder Abuse grant allowed for the hiring of a specialized intake worker in the Informational and Referral Unit of the Rhode Island DEA. It proved extremely difficult to transfer abuse reports to one person, and a decision was made to share elder abuse intake duties among the entire I and R staff, who were similarily trained to accept this responsibility. It appears that where there is some overlap between EAP workers and previously existing staff, "turf" issues are likely to emerge. The EAP must be sufficiently flexible to defuse conflicts that arise, as the Worcester and Rhode Island sites were.

Interesting findings emerged relating to interagency coordination. As noted above, one major problem that is often encountered by new programs - obtaining clients - did not occur here. The EAPs overcame this by visiting nearly all relevant agencies in their areas; utilizing the media for announcements, training; and other related methods. After such initial attempts, cases came quickly. In fact, the EAP workers found other agencies only too willing to transfer complicated and frustrating abuse cases to them.

A more specific problem occurred in the Syracuse and Rhode Island sites. In both locations, an Adult Protective Services Unit existed in another agency, that at least legally had overlapping responsibilities with the EAP. Both Projects were thus forced to answer the question: what is special about what you offer? These two Projects were able to come to terms with the APS units. They convincingly argued that they were free of the stigma of welfare agencies (in which both APS programs were located). By maintaining open lines of communication with the APS programs, and in particular showing a willingness to relieve them of especially troublesome clients, the EAPs avoided serious conflict. The clear specification of the resepective roles of EAPs and APS's in elder abuse should be worked out prior to the implementation of an EAP, if implementation is to be as smooth as possible. Beyond this issue, all three EAPs had extensive contact with other community agencies. All developed both informal and formal mechanisms of maintaining agency linkages.

The EAPs were asked to list the agencies (up to five) with whom they worked most closely. These were very similar: all three projects included a home health agency, and a senior center in their choices. Syracuse and Rhode Island added the Adult Protective Unit in the Welfare Department, with whom coordination was essential. Rhode Island was unusual in that it listed the Police Department as an important co-operating agency. Due to their increased legal responsibilities under mandatory reporting, the Rhode Island maintained much closer ties to the police than the other EAPs.

A number of possible problems can arise in interagency coordination. The major issue which must be determined among the agencies involved is who will manage the case. The most usual way in which this is decided is based on what is considered to be the primary problem. If the major problem is health-related, the VNA is likely to take charge, and call the EAP in the consultation. If the case presents itself originally as an abuse case, the EAP will tend to manage it, and call in other agencies as needed.

Interagency coordination was found to be especially critical for Rhode Island and Syracuse, and less so for Worcester. This is due to the nature of the models. Worcester controls many services within its own agency; it therefore required less contact with other agencies (conversely, it for the same reason experienced more coordination problems within the agency). Rhode Island and Syracuse responded to the coordination problem by employing formal mechanisms.

The Syracuse model, as noted above, is based on coordination. For every client, a "team" is established, which usually involves at a minimum a Public Health Nurse and Adult Protective services worker. The

Figure 9 MODEL PROJECT SERVICES

	Metropolitan Commission on Aging of Onondaga County: ALLIANCE/Catholic Charities	Massachusetts Department of Elder Affairs	Rhode Island Department of Elderly Affairs
Home Health Care	+	+	+
Homemaker Services	+	*	+
Supplementary Services for care-receivers	+	*	+
Elder Abuse Aides	*	+	0
Hot Line	+	*	*
Emergency Shelter	+	+	+
Respite	+	+	0
Counseling	+ *	+ *	+ *
Support Groups for caregivers	*	0	0
Mandatory Reporting	0	*	*
Case Assessment	*	*	*
Case Monitoring	*	*	*
Agency/Staff Training	*	*	*
Elder Awareness Training	0	0	*
Community Education	*	*	*
Community Legal Aid	+	+	+
Research Evaluation	*	*	*

* = direct service
+ = coordinate service
0 = no service

prepared by Julia Hannum, Department of Human Services Studies, Cornell University, Ithaca, New York.

team meets formally to review the progress of the case, and augments this with informal telephone contact. Rhode Island made use of "key councils," which are interagency groups of elder service providers that meet at regular intervals. A special subcommittee of the Providence Key Council was established to work specifically with the Rhode Island EAP.

The greatest difficulties in interagency coordination were experienced by the Rhode Island EAP, and seem to be attributable to the constraints by mandatory reporting. In particular, as noted above, the Rhode Island EAP received a very large number of referrals; many more than could have been handled by Project staff. Therefore, an attempt was made to transfer control of cases to other agencies as quickly as possible. Although this was unavoidable, it posed problems for the agencies concerned. Specifically, Worcester and Syracuse had concrete services to offer; Worcester authorized a range of home care services, and Syracuse has specialized case aides. The Rhode Island EAP, on the other hand, was designed to involve other agencies in case management, for which, because of time constraints, they had less to offer in return. DEA has made several recent attempts to overcome these problems in interagency coordination.

Another perspective on the Model Projects' operations is given in Chapter Eight, which presents the results of a survey of community agencies at the end of the grant period.

CHAPTER EIGHT

SURVEY OF COMMUNITY AGENCIES (II)

In addition to the qualitative data which were collected for the organizational analysis just described, local agencies were surveyed two years apart in each of the Project sites to address two of the initial research questions (see page 5): What is the impact of the outreach and case finding techniques on the reporting of elder abuse cases in a geographic area and what is the impact of the Model Project on elder abuse in the geographic area? This chapter begins with a brief summary of the first Survey (I),* followed by a description of the methodology and results of the second Survey (II) and a comparison of selected findings from both of them.

I. Summary of Findings from Survey I

During the first year of the grant, a questionnaire was distributed to health, mental health, social service, elder service, legal and law enforcement agencies in Worcester and fifteen surrounding towns (MA), Boston (MA), Onondaga County (NY), and Rhode Island. It included questions on awareness of elder abuse/neglect, reluctance or willingness to report, number and types of cases, referral sources and resource needs and, in three of the four sites, a training needs assessment. Data collection covered the six month period prior to full operation of the Model Project.

From the 280 questionnaires that were returned in the four sites, it was evident that almost all agencies were aware of elder abuse and not reluctant to report it. An attempt to obtain statistics on the number of cases of abuse and neglect, either in total or by type (physical, psychological, material, active and passive neglect) was hampered because of the difficulty in identification of cases, confusion between neglect by others and self-neglect, and perhaps the lack of experience on the part of the respondents with the classification system. While there were variations among the three Model Projects in the relative importance given the type of organizations involved in the communities' referral patterns the agencies most often called upon for handling abuse and neglect cases, included programs for the elderly, social agencies, home health organizations, legal services and the police. The most needed resource in all sites was emergency shelter; the most often mentioned training need was information about local resources.

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*See "Preliminary Findings from Three AOA Model Projects on Elderly Abuse," for description of methodology and results of Survey I, Appendix II, Exhibit 1

II. Findings from Survey II

A. Methodology

In addition to the questions which had appeared in Survey I, Survey II included several more relating to the outreach and educational efforts of the Model Projects (See Appendix I, Exhibit 8). Dissemination and collection of survey forms were undertaken by the Syracuse and Rhode Island Project staff for Onondaga County and the state of Rhode Island, respectively and by the Evaluation Team in consultation with the Worcester Project Director for the Worcester area. One hundred and forty questionnaires were mailed by the Evaluation Team in the Worcester Area, and 64 were returned. Telephone calls and a second mailing produced an additional 37, for a total of 101. Approximately 100 forms were mailed to agencies in Onondaga County, and 52 were returned. Rhode Island distributed about 200 throughout the state and obtained 60 replies. Neither the Syracuse or the Rhode Island project were able to assign staff to do the follow-up necessary to bring in additional forms.

Table 8.1 gives the number and percentage of returns by agency type for the three sites. The largest share of responses in both the Worcester area (15.9 percent) and Rhode Island (21.7 percent) was from health facilities, while in Onondaga County (Syracuse), the police departments and religious organizations accounted for the highest proportion (17.3 percent each).

B. Results

Awareness of Elder Abuse/Neglect

The agencies were asked three questions concerning their involvement with elder abuse/neglect cases: had they known at least one case of elder abuse/neglect; were they aware of the problem, but had not encountered a case; or were they unaware of the problem. About one half of the Worcester respondents (48.5 percent) had known at least one case, about one third (31.7 percent) was aware of the problem but had not encountered specific cases, and approximately one-sixth (18.8 percent) was not aware of the problem. The results in Onondaga County showed that more than half the group (57.7 percent) had known at least one case, almost one-third (30.8 percent) was aware but had not encountered specific cases, and about one-ninth (11.5 percent) was not aware. Among the Rhode Island agencies, three fifths (60.0 percent) had known at least one case, slightly more than one-quarter (26.7 percent) had not encountered a case, and about one-eighth (13.3) was not aware of the problem (Table 8.2).

Community Response System

To learn more about the community response system for elder abuse/neglect cases in the three sites, the respondents who had not encountered a case were asked to name "the agency(ies) you would think of turning to if you had a case." Two-thirds (68.4 percent) of the Worcester area agencies listed the Model Project (Table 8.3). The next

TABLE 8.1 TYPE AND NUMBER OF AGENCIES RESPONDING TO SURVEY II

	Worcester Area n=101	Onondaga County n=52	Rhode Island n=60
	# %	# %	# %
Boards of Health/Health Depts.	8(7.9)	1(1.9)	-
Churches/Religious Organizations	2(2.0)	9(17.3)	-
Day Care Programs	3(3.0)	-	1(1.7)
Elder Services/Councils-Aging/AAA	15(14.9)	8(15.3)	8(13.3)
Health (Hospitals, Health Ctrs.)	16(15.9)	4(7.7)	13(21.7)
Home Health Agencies	12(11.9)	6(11.5)	6(10.0)
Housing/Emergency Shelters	10(9.9)	1(1.9)	3(5.0)
Legal Services	4(4.0)	-	-
Mental Health Services	6(5.9)	2(3.8)	7(11.7)
Neighborhood Centers	5(5.0)	1(1.9)	1(1.7)
Police	12(11.9)	9(17.3)	11(18.3)
Social Services	8(7.9)	8(15.4)	2(3.3)
State/County Agencies	-	1(1.9)	8(13.3)
Miscellaneous	-	2(3.8)	-

TABLE 8.2 AWARENESS OF ELDER ABUSE/NEGLECT CASES

	Worcester Area n=101	Onondaga County n=52	Rhode Island n=60
	# %	# %	# %
a) Agency has known at least one case	48(48.5)	30(57.7)	36(60.0)
b) Agency is aware, but has not encountered any cases.	32 (31.7)	16(30.8)	16(26.7)
c) Agency is not aware of elder abuse/neglect.	19(18.8)	6(11.5)	8(13.3)

TABLE 8.3 COMMUNITY REFERRAL SYSTEM FOR CASES OF ELDER ABUSE/ NEGLECT IN THE WORCESTER AREA

	Agencies you "would turn to" n=38	Agencies you "turned to" n=46
	# %	# %
Boards of Health/Health Dept.	2(5.3)	1(2.2)
Councils on Aging/AAA	8(21.1)	2(4.3)
Courts/Judicial	1(2.6)	-
Elder Services	6(15.8)	10(21.7)
Health (Hopsitals, Health Centers)	4(10.5)	3(6.5)
Home Health Agencies	7(18.4)	7(15.2)
Legal Services	5(13.2)	6(13.0)
Mental Health Services	1(2.6)	6(13.0)
MODEL PROJECT	26(68.4)	38(82.6)
Nursing Homes	-	1(1.2)
Physicians	2(5.3)	2(4.3)
Police	3(7.9)	1(2.2)
Religious/Church	-	1(2.2)
Shelters	1(2.6)	3(6.5)
Social Service Agencies	2(5.3)	2(4.3)
State Agencies	1(2.6)	2(4.3)
Within Agency Referrals	6(15.8)	2(4.3)
Other	1(2.6)	-

most often cited agencies included the Councils on Aging (21.1 percent), Home Health Agencies (18.4 percent), within agency referrals (usually a hospital emergency room to their social services department) (15.8 percent) and Legal Services (13.2 percent). Among the Onondaga County respondents almost seven-eighths (86.7 percent) named the Model Project and one-fifth (20.0 percent), the Adult Protective Services Unit of the Department of Social Services (Table 8.4). In Rhode Island, almost three quarters (73.7 percent) referred to the Model Project and two-fifths (42.1 percent) to other State Agencies (Table 8.5).

When the question was re-worded to "the agency you turned to when you had a case," four-fifths (82.6 percent) of the respondents in the Worcester area who had encountered at least one case listed the Model Project and about one-fifth (21.7 percent), Elder Services (Table 8.3). Among a similar group in Onondaga County, seven-tenths (69.0 percent) named the Model Project and the Adult Protection Services Unit of the Department of Social Services (69.0 percent) and slightly more than one-quarter (27.6 percent), the Health Department (Table 8.4). With respect to the agencies in Rhode Island that had encountered a case, about six sevenths (86.1 percent) turned to the Model Project, one-third (33.3 percent) to Mental Health Services, and about one-quarter (27.8 percent) to other State Agencies (Table 8.5).

Service Needs

In response to the question asking for a list of services "which are needed but presently unavailable," about a quarter of the agencies in Worcester (26.7 percent) and Onondaga County (26.9 percent) and a somewhat larger percentage (43.3 percent) in Rhode Island chose to reply. Over twenty different resources were named. Respite care was cited by eight Worcester agencies and emergency shelter, by seven. All other services received fewer citations. None of the services listed by the Onondaga County agencies were mentioned more than three times or by the Rhode Island group, more than five times (Table 8.6).

Procedures for Dealing With Abuse/Neglect Cases

To obtain additional information about the local response system, the agencies were asked whether the agency has a specific procedure for dealing with suspected cases. Among the Worcester organizations, there were almost four out of ten that replied affirmatively (37.0 percent), a somewhat larger proportion in Onondaga County (45.1 percent) and more than half the Rhode Island agencies (53.4 percent). However, only 27.8 percent of the Worcester group had written policies or guidelines, about 26.1 percent of those in Onondaga County and 58.6 percent of those in Rhode Island (Table 8.7). The survey form then asked those that answered "no" to describe the way they would handle a case.

Of the 79 respondents to this question from the Worcester area, 36 cited the Model Project in their explanation. When reviewing the answers, it was apparent that Elder Home Care, the Worcester Project, was more apt to be named by home health and social service agencies and

TABLE 8.4 COMMUNITY REFERRAL SYSTEM FOR CASES OF ELDER ABUSE/NEGLECT IN ONONDAGA COUNTY, NEW YORK

	Agencies you "would turn to" n=15	Agencies you "turned to" n=29
	# %	# %
Boards of Health/Health Dept.	1(6.7)	8(27.6)
Councils on Aging/AAA	2(13.3)	1(3.4)
Courts/Judicial	-	1(3.4)
Elder Services	-	-
Health (Hospitals, Health Ctrs.)	-	-
Home Health Agencies	1(6.7)	3(10.3)
Legal Services	-	1(3.4)
Mental Health Services	1(6.7)	2(6.9)
MODEL PROJECT	13(86.7)	20(69.0)
Nursing Homes	-	-
Physicians	-	-
Police	-	1(3.4)
Religious/Church	-	1(3.4)
Shelter	-	3(10.3)
Social Services	-	5(17.2)
State Agencies	3(20.0)	20(69.0)
Other	1(6.7)	1(3.4)

TABLE 8.5 COMMUNITY REFERRAL SYSTEM FOR CASES OF ELDER ABUSE/ NEGLECT IN RHODE ISLAND

	Agencies you "would turn to" n=19	Agencies you "turned to" n=36
	# %	# %
Boards of Health/Health Depts.	-	-
Councils on Aing?AAA	-	-
Courts/Judicial	-	1(2.8)
Elder Services	3(15.8)	5(13.9)
Health (Hospitals, Health Ctrs.)	2(10.6)	4(11.1)
Home Health Agencies	1(5.3)	8(22.2)
Legal Services	-	2(5.6)
Mental Health Services	3(15.8)	12(33.3)
MODEL PROJECTS	14(73.7)	31(86.1)
Nursing Homes	-	1(2.8)
Physicians	-	1(2.8)
Police	3(15.8)	8(22.2)
Religious/Church	-	1(2.8)
Shelter	-	1(2.8)
Social Services	2(10.5)	4(11.1)
State Agencies	8(42.1)	10(27.8)
With Agency Referral	1(5.3)	1(2.8)
Other	2(10.5)	11(30.6)

TABLE 8.6 SERVICES WHICH ARE NEEDED TO HELP ELDER ABUSE/NEGLECT CASES BUT WHICH ARE UNAVAILABLE

	Worcester Area n=27	Onondaga County n=14	Rhode Island n=26
	#	#	#
Agency staff education	2	1	-
Advocacy	1	-	1
Companion services	3	-	1
Comprehensive/coordinated service	1	-	4
Conservatorship/guardianship	3	-	2
Counseling/stress management	1	1	5
Crisis intervention	-	1	1
Emergency shelter	7	2	5
Financial assistance	2	2	-
Foster homes	1	-	3
Home visits	-	1	3
Hot line	1	-	-
Housing arrangements	2	-	5
Legal services	2	2	2
Mandatory reporting	1	1	-
Medical/psychiatric outreach	-	1	2
Nursing homes	1	-	-
Peer support	2	-	-
Protective services legislation	-	1	2
Public education	3	-	1
Reimbursement - easier	1	-	-
Respite facilities	8	3	2
Staff workers	1	-	-
Other	3	3	6

least likely to be cited by the police, municipal boards of health, and legal programs. In analyzing the method of handling the cases, the responses seem to fall into two categories: refer/contact and investigate/ collect information. Except for the local councils on aging which referred in all cases, the other agencies were equally divided between those which would investigate and assess the situation first and those that would refer or report to an outside group.

Among the 37 Onondaga County area respondents to the question, thirteen cited the Alliance, the Syracuse Elder Abuse Project as the agency they would call upon. Again, this latter group was generally comprised of senior programs, home health agencies and the churches, rather than the police departments or the hospitals. Similar to the action pattern in Worcester, the senior programs in Onondaga County normally referred the case directly; the police and the state units investigated; and others were also evenly divided between investigation and referral.

Thirty agencies in Rhode Island answered, of which eighteen mentioned that they would contact the Department of Elderly Affairs Model Project. This latter group consisted mostly of the social service and health organizations. The police were least likely to list the Model Project. Reporting or referral was the most common method of handling abuse situations for social service, health, and senior programs; investigation for the police; and assessment, then referral, for the mental health programs.

Effectiveness of the Model Project

The next four questions on the survey form were intended to assess the effectiveness of the Model Projects. More than three quarters of the respondents in all sites noted on the questionnaire that they were aware that a specific project existed in the area to deal with abuse (Worcester, 78.0 percent; Onondaga County, 86.5 percent; and Rhode Island, 64.6 percent). When asked to rate the response of the Projects, 86.0 percent of the Worcester agencies marked "excellent"; 56.5 percent, Onondaga County; and 32.3 percent, Rhode Island. If the "excellent" and "good" replies are combined, the total percentage for Worcester is 95.3; for Onondaga County 95.6 and for Rhode Island, 80.7 (Table 8.7).

A final question in this set asked those agencies that had made a referral to provide details about the response of the Model Project. Thirty-nine agencies in the Worcester survey answered this question, of which thirty-six were very positive. Seven noted that the response was immediate or prompt; four stated that the service was excellent and three remarked on its comprehensiveness. A varity of Model Project activities was listed (e.g., case management, home visits, case work, legal assistance, assessment, consultation, etc.) the most often of which was (by four of 39) "follow-up." Of the two agencies that answered negatively, one was a council on aging which stated that it had not received a follow-up report; the second was a neighborhood center which wrote that

TABLE 8.7 AGENCY PROCEDURES FOR DEALING WITH CASES OF ELDER ABUSE/NEGLECT AND AWARENESS AND RESPONSE FROM MODEL PROJECTS

	Worcester Area n=101	Onondaga County n=52	Rhode Island n=60
	# %	# %	# %
a) Agency has a specific procedure for dealing with suspected cases of abuse/neglect:			
Yes	37(37.0)	23(45.1)	31(53.4)
No	63(63.0)	27(54.9)	27(42.6)
No answer	1	1	2
b) If YES, agency has documented guidelines/written policies for dealing with cases:			
Yes	11(26.8)	9(29.0)	17(51.5)
No	30(73.2)	22(71.0)	16(48.5)
No answer	60	21	27
c) Agency is aware that there is a specific project in area dealing with elder abuse/neglect:			
Yes	78(78.8)	45(86.5)	43(75.4)
No	21(21.2)	7(13.5)	14(24.6)
No answer	2	-	3
d) If YES, agency has referred a client to the project:			
Yes	42(51.9)	21(47.7)	31(66.0)
No	39(48.1)	23(52.3)	16(34.0)
No answer	20	8	13
e) If YES, the response from the project:			
Excellent	37(86.0)	13(56.5)	10(32.2)
Good	4(9.3)	9(39.1)	5(48.4)
Fair	2(4.8)	1(4.3)	6(19.4)
Poor	-	-	-
No answer	58	29	29

> ...they did not seem enthusiastic...then I had to give them some direction as to how to solve the problem...

This statement appears to be contrary to the sentiments expressed by all the other respondents.

Twenty-two of the 52 agencies completing the questionnaire in Onondaga County provided comments concerning their Model Project. Except for two which included these statements:

> ...there was considerable delay before action could be taken, which probably was attributable to lack of adequate staff...

> ...lack of understanding of the health care system"

all were positive. Four answers noted the "promptness of the response and three described the Model Project's efforts as "very good." Again, in the listing of activities provided by the Model Project, none appeared more often than any other (i.e., placement of aides, contacted social service, counseling, made home visits, excellent training, etc.) except for "follow-up" which was mentioned by three of the agencies.

Among the Rhode Island agencies that completed the survey form, thirty-four added comments. Of these, thirty were favorable. Seven cited the timeliness of the response, and five used the adjective, "good" regarding the Project's input and advice. In describing the nature of the response, the agencies mentioned many tasks (e.g., investigated, communicated, made home visits, arranged conference, etc.), no one of which was cited more than three times. The negative comments included, "lacking follow-up" and "role definition and disposition of cases not equally consistent." Two statements from mental health agencies indicate need for further clarification:

> ...Although response was good, I felt that there was little if anything the project could offer us.. The mental health agency seemed to provide much more service than it received. Perhaps, the expectations of what the project could provide to community agencies was never clear...

> ...There appears to be a basic difference between how some staff at our agency perceive the Project's role and how the project perceives its role. In some instances where there is a documented potential for abuse/neglect in the community, agency staff have sought to assure monitoring of clients following discharge. In such cases, Project staff have apparently seen their role as preventing discharge rather than monitoring the client in the community...

Coordination of Services

Because of the importance of "coordination" in providing services to abused and neglected elders, the agencies were asked "if involved in cases of abuse, indicate the degree of satisfaction with the extent of cooperation or coordination of services in your area." Again, the most positive response came from the agencies in the Worcester site, over two-thirds of whom (68.9 percent) marked "very satisfied," and a little over one-quarter (28.9 percent) as "reasonably satisfied." The Onondaga County agencies were almost equally divided with 46.2 percent saying that they were "very satisfied" and 53.8 percent as "reasonably satisfied." Among the Rhode Island agencies, there were about one-third (35.3 percent) who were "very satisfied" and almost two-thirds 61.8 percent, "reasonably satisfied." One agency response in both the Worcester and Rhode Island surveys marked "not at all satisfied" (Table 8.8)

Number and Type of Cases

Because of the wide interest in the extent and prevalence of elder abuse and neglect, both Survey I and II included questions on the number and type of cases seen by community agencies. As mentioned earlier, the attempt to obtain the number of elder abuse and neglect cases as a proportion of total case load in Survey I was not successful. Many of the responding agencies were unable to provide data on "case load" because the term was inappropriate (e.g., churches, police, senior centers, etc.) and, when reporting cases, failed to distinguish between the number of cases and individuals and between abuse and neglect by caretakers and self-neglect. To avoid some of the latter confusion, the directions in Survey II were made more explicit, specifying the categories to be excluded (i.e., institutional, professional, and self-abuse) and asking for both the number of cases by type and the number of individuals involved. The question on case load was dropped. A six month period, corresponding to that one in Survey I, but two years later, was chosen for data collection.

The total number of cases from the Worcester area was 223, compromising 148 individuals. There were 290 cases represented by 190 individuals for Onondaga County, and Rhode Island agencies reported 182 cases involving 157 elders. In Worcester, the most prevalent types of abuse/ neglect were passive neglect, first (31.4 percent), psychological abuse, second (26.9 percent) and material abuse, third (20.2). Physical abuse comprised 15.2 percent of cases and active neglect, 6.4 percent. Both Onondaga County and Rhode Island agencies found psychological abuse to be the most common type (27.9 and 33.0 percent respectively). Next most often cited type in the New York county was material abuse (26.6 percent), followed by passive neglect (21.0 percent), physical abuse (13.4 percent) and active neglect (11.0 percent). After psychological abuse, the Rhode Island respondents indicated that passive neglect was most common (20.9 percent), then physical (18.1 percent), material (14.8 percent) and active neglect (13.2) (Table 8.9).

TABLE 8.8 SATISFACTION WITH COORDINATION OF SERVICES

	Worcester Area n=101	Onondaga County n=52	Rhode Island n=60
	# %	# %	# %
Agency has been involved with cases of elder abuse/neglect and rates degree of satisfaction with extent of cooperation or coordination of services:			
Very satisfied	31(68.9)	12(46.2)	12(35.3)
Reasonably satisfied	13(28.9)	14(53.8)	21(61.8)
Not at all satisfied	1(2.2)	-	1(2.9)
No answer	56	26	26

TABLE 8.9 NUMBER AND PERCENT OF CASES OF ELDER ABUSE AND NEGLECT BY TYPE REFERRED TO COMMUNITY AGENCIES FOR A SIX MONTH PERIOD, 1982-83.

	Worcester Area n=101	Onondaga County n=52	Rhode Island n=60
	# %	# %	# %
Physical abuse	34(15.9)	49(13.4)	33(18.1)
Psychological abuse	60(26.9)	81(27.9)	60(33.0)
Material abuse	45(20.2)	77(26.6)	27(14.8)
Active neglect	14(6.4)	22(11.0)	24(13.2)
Passive neglect	70(31.4)	61(21.0)	38(20.9)
Total cases	223(100.)	290(99.9)	182(100.)
Total individuals	148	190	157

Effectiveness of Education/Training Presentations

One of the purposes of Survey II was to evaluate the education and training activities of the Model Projects. A four part question was included in the questionnaire which asked whether the staff of the community agency had attended a program or presentation on elder abuse and neglect in the previous two years, the type of program, the organizer or sponsor and the rating (excellent, good, fair or poor). Approximately two-fifths (40.8 percent) of the respondents in the Worcester survey replied that they had attended a program, and about three-fifths in Onondaga County (58.0 percent) and Rhode Island (61.8 percent). Thirty-three of the forty Worcester agencies that answered the question specified the type of program. Most often cited was inservice education (13), followed by conferences (7), workshops (6) and lectures (5). Of the sponsors or organizers of the programs listed on the forms, the Model Project received the highest number of citations (13). The next most often mentioned sponsor was "the community mental health center," noted five times. All others were listed fewer times. Ratings for the Model Project programs included seven "excellent" and six "good" (Table 8.10).

Providing detailed information about the education and training programs in the Onondaga County survey were about half the respondents, 27 agencies. Again, inservice was the most common form of program (13 agencies checked this type), followed by workshops (8). Among the program sponsors given on the forms, the Model Project's name appeared seventeen times, followed by the Metropolitan Commission on Aging of Onondaga County, listed seven times. Twelve of the Elder Abuse Project programs were rated as "excellent"; four, "good"; and one, "poor."

Thirty-seven of the sixty surveys returned by the Rhode Island agencies stated that the staff had attended a program on elder abuse in the previous two years. Among these agencies, twenty-nine furnished details concerning type, sponsor and quality. Fifty-four programs were listed, the most common type of which were workshops and conferences, each cited thirteen times, and inservice, ten times. Nineteen different sponsors of programs were included in the survey forms. The Model Project was cited twenty-two times and, the next most often listed organizers was the Providence Mental Health Center and Department of Social and Rehabilitation services, each four times. The ratings for the Rhode Island Model Project programs included twelve "excellent" and seven "good."

The final request on the survey form was for "additional comments." A third of the agencies in the Worcester area (35) did respond. Eleven of them asked for more information (i.e., about training, the new law, etc.); six mentioned the need for assistance with problems of self-abuse and neglect; five praised the Project; four added information related to abuse (the perspective of an alcoholism program and women's shelter); and four stated that there was no abuse in their town. Twenty Onondaga County agencies provided additional coments on the questionnaire, six of which commended the work of the Model Project, three stated that they had not encountered any abused elders, two provided added information about the nature of abuse and two asked for more information. On the

TABLE 8.10 EDUCATION AND TRAINING PROGRAMS ON ELDER ABUSE/NEGLECT

	Worcester Area n=101	Onondaga County n=52	Rhode Island n=60
	# %	# %	# %
a) Staff attended a program on elder abuse/neglect in previous two years:			
Yes	40(41.7)	29(58.0)	34(61.8)
No	56(58.3)	21(42.0)	21(38.2)
No answer	5	2	5
b) Type of programs attended:*	n=33	n=27	n=37
Conferences	7	4	13
Courses	-	-	1
Inservice	13	13	10
Lectures	5	3	4
Seminar series	4	1	5
Workshops	6	8	13
Other	2	5	8
c) Sponsor of programs attended:*	n=30	n=25	n=29
Aging organizations	9	8	7
Educational institutions	3	1	-
Home health agencies	3	2	2
Hospitals	4	2	4
Mental health agencies	6	7	3
MODEL PROJECT	15	22	16
Social services	2	2	2
State/County Agencies	3	-	7
Other	4	3	1

*Multiple responses given.

TABLE 8.11 ADDITIONAL COMMENTS

	Worcester Area n=35	Onondaga County n=20	Rhode Island n=18
More information/training	11	3	3
More information: self-abuse	6	-	2
Praised project	5	6	2
No elder abuse/neglect	4	3	-
Added comments about nature of abuse	4	2	-
Request for legislation	-	1	2
Clarification of role	-	1	2
Other	5	4	7

Rhode Island survey forms there were additional comments from nineteen of the 60 respondents: three requested more information, two cited the need for help with self abused elders, two called for legislation similar to that in effect for child abuse cases, two asked for the opportunity to clarify the role of the Model Project vis-a-vis community agencies and two applauded the Project for its efforts (Table 8.11).

C. Discussion

In all three sites, Survey II forms were completed by a fairly wide range of human service agencies. The variance in the respondents among the three Projects seems to be related to the type of sponsorship, traditional lines of communication of sponsors and the organizational structure of the community. For instance, the Syracuse Project, which operated under the auspices of Catholic Charities of Syracuse, was able to reach out to neighborhood churches through an existing network. Worcester and Rhode Island Projects did not have this advantage and consequently did not include this sector of community life in their surveys. The Worcester agency (Elder Home Care) had been working closely with several legal agencies before the initiation of Elder Abuse project. They completed the survey. No legal service units returned the questionnaire in the other two sites. The good response from the police departments in all the localities is indicative of police practice rather than involvement of law enforcement officers with the Elder Abuse Projects or elder abuse/neglect cases. Actually, very few of the reporting police departments had handled a case. Although a large majority of the agencies in three localities were aware of elder abuse or had encountered a case, there were still some agencies among those returning forms that were not aware of the problem.

The Model Projects were viewed by a large proportion of respondents as the "agency they would turn to" with a case of elder abuse or neglect; an even larger proportion reported that they had indeed "turned" to the Projects. Other agencies which were mentioned as referral sources for cases varied by community. For Worcester, it was apt to be voluntary programs serving the elderly; in Syracuse, the Adult Protective Services Unit of the Department of Public Welfare and in Rhode Island, mental health organizations and state agencies, again reflective of the organization of the human service system in the specific localities.

In none of the sites did there appear to be any compelling service needs. It is interesting that less than half of the respondents chose to answer the question about "services that are needed but currently unavailable." About the same proportion of agencies also said that they had specific procedures for dealing with suspected case, ranging from a little more than one in three of the Worcester group to just over one in two of the Rhode Island responders, with the Syracuse group midway between the other two, although only a portion of these agencies had written guidelines. Those without special policies either made referrals directly to other agencies for identification and assessment purposes, or carried out a their own preliminary investigation. Senior programs, social service organizations, and churches were more likely to do the former, while police and hospitals were involved in the latter.

More than three-quarters of the agencies returning survey forms stated that they were aware that there was a special project in their community to handle elder abuse and neglect cases and over half of that group stated that they had made a referral. A large percentage of these respondents rated the service as "excellent or good." About one third of the forms in each of the sites included additional complimentary comments. Apparently, Worcester was most successful in coordinating services, with more than two thirds of the community agencies replying that they were satisfied with the cooperation or coordination of services compared to slightly less than one half of the Syracuse group and one-third of the Rhode Island program, results which mirror those found in the organizational analysis (Chapter Seven).

The community agencies were again requested, as they had been in Survey I, to give the number and type of cases of elder abuse and neglect which they had seen during a six month period. Since there was no way of determining whether the same case was being reported by more than one agency, including the Model Projects, it is difficult to explain the meaning of the totals, except that, generally, the numbers appear to be high compared to those furnished by the Model Projects. For example, the Worcester Project handled 59 validated cases of elder abuse and neglect in the period July 1, 1981 - June 30, 1983 while the individuals reported by community agencies for the period October 1, 1982 - March 30, 1983 was 148. The Syracuse Project's case load for the two year period was 135; the community agencies reported a total of 190 individuals; one hundred and thirty-four validated cases were handled by the Rhode Island Project; the total for the survey form was 157. Of the various types of abuse and neglect reported, active neglect was encountered in the smallest numbers for all sites. Psychological abuse and passive neglect tended to be reported more often than physical or material abuse.

A final series of questions on Survey II dealt with the effectiveness of the training/education programs conducted by the Model Projects. Each project had included an education/training objective in its application for AOA funding. The Worcester and Syracuse Projects' approach was mainly to provide on-going consultation and conduct inservice programs. The Syracuse Project also sponsored a one-day program for community agencies during the first year of the project. A more extensive and intensive educational effort was mounted by the Rhode Island Project not only providing on-going consultation and inservice education but also sponsoring a playlet about elder abuse and neglect, which was seen by many elderly groups, and conducting state-wide conferences which featured abuse and neglect. About two out of five of the respondents did participate in educational programs of one type or another in the Worcester area and about three out of five in the Syracuse and Rhode Island sites. The Rhode Island agencies were more likely to report attendance at conferences and workshops while the Worcester and Syracuse groups checked "inservice" more often. For all three sites, the most often mentioned sponsor of educational programs in their area was the Model Project.

In summary, the results indicate that a representative group of agencies in all sites completed the survey, a large majority of which were aware of elder abuse or had encountered a case. They knew of the existence of the Model Project, had referred a case, and were satisfied with the service. A sizable proportion had participated in educational programs. Surprisingly, no outstanding "needs" were mentioned in any of the three localities and almost every respondent was at least reasonably satisfied with the extent of cooperation and coordination of services which existed in the respective area.

III. Comparison of Selected Findings for Survey I and II

In order to determine whether any changes had occurred in the perception of community agencies regarding elder abuse and neglect and the role of the Model Projects during the course of the demonstration, some questions appearing in Survey I were repeated in Survey II. A comparison of the findings is presented below.

A. Results

Survey Respondents

In addition to the agencies contacted in Survey I, the mailing list for the second survey in the Worcester area was expanded to include those agencies with which the Project Director had contact during the two year period. Of the 101 respondents to Survey II, 64 had completed Survey I, and 37 were new. Twenty-two agencies that had completed Survey I did not return II. Using approximately the same mailing list, the Syracuse Project received replies from 42 agencies that also had responded to Survey I, and 10 new ones; 14 agencies that had submitted forms in the earlier survey, did not participate in the second one; the Rhode Island returns for Survey II included 29 agencies that had completed both the first and the second questionnaire; 42, only the first, and 31, only the second.

In spite of the loss of some Survey I agencies in Survey II and the gain of new ones, the pattern of agencies responding to the two surveys in the three sites are quite similar. For the Worcester group, there is a slightly lower proportion of elder service agencies (14.9 percent compared to 18.7 percent), health institutions (15.9 percent instead of 20.9 percent) and police departments (11.9 percent rather than 16.3 percent), but an added group of housing units (9.9 percent). The types of responding agencies to the surveys in the Onandata County area are very much alike, except for fewer police departments the second time, 17.3 percent compared to 25.5 percent. The Rhode Island returns show differences in two categories: fewer "elder services," from 25.4 percent (Survey I) to 13.3 percent (Survey II), and forces from state agencies (0.0 percent compared to 13.3 percent) (Table 8.12).

Level of Awareness

To clarify some ambiguity in the question on the level of awareness

TABLE 8.12 . TYPE AND NUMBER OF AGENCIES RESPONDING TO SURVEY I AND SURVEY II

	Worcester Area		Onondaga County		Rhode Island	
	I n=86	II n=101	I n=55	II n=52	I n=71	II n=60
	# %	# %	# %	# %	# %	# %
Boards of Health/Health Depts.	7(8.2)	8(7.9)	1(1.9)	1(1.9)	–	–
Churches/Religious	1(1.2)	2(2.0)	9(16.4)	9(17.3)	–	–
Day Care Programs	1(2.4)	3(3.0)	–	–	–	1(1.7)
Elder Services/Councils on Aging/AAA	16(18.7)	15(14.9)	7(12.8)	8(15.3)	18(25.4)	8(13.3)
Health (Hospitals, Health Ctrs.)	18(20.9)	16(15.9)	4(7.3)	4(7.7)	20(28.2)	13(21.7)
Home Health Agencies	10(11.6)	12(11.9)	6(10.9)	6(11.5)	4(5.6)	6(10.0)
Housing/Emergency Shelter	–	10(9.9)	2(3.7)	1(1.9)	7(9.9)	3(5.0)
Legal Services	3(3.5)	4(4.0)	–	–	–	–
Mental Health Agencies	3(3.5)	5(5.9)	2(3.7)	2(3.8)	7(9.9)	7(11.7)
Neighborhood Centers	4(4.7)	5(5.0)	–	1(1.9)	2(2.9)	1(1.7)
Police	14(16.3)	12(11.9)	14(25.5)	9(17.3)	9(12.7)	11(18.3)
Social Services	4(4.7)	8(7.9)	6(10.9)	8(15.4)	4(5.7)	2(3.3)
State/County Agencies	1(1.2)	–	1(1.9)	1(1.9)	–	8(13.3)
Miscellaneous	–	–	3(5.5)	2(3.8)	1(1.4)	–

which appeared in Survey I, the wording in Survey II was changed from two choices: 1) the agency has known at least one case; and 2) the agency is aware, but has not encountered any cases; to include a third. 3) the agency is not aware of elder abuse or neglect. Consequently, comparisons cannot be made for all parts of the question. A few agencies in each site did not answer the question.

According to Table 8.13, the proportion of agencies knowing at least one case was somewhat larger in Survey II (48.5 percent, Worcester; 57.7 percent, Onondaga County, 60.0 percent, Rhode Island) than Survey I (40.7 percent, 49.1 percent, 53.5 percent), although it is not possible to say whether it was a significant increase. A larger percentage of Survey I agencies (55.8 percent, Worcester; 47.8 percent, Onondaga County; 40.9 percent, Rhode Island) acknowledged that there were aware of cases than those in Survey II (31.7 percent, 30.8 percent and 26.7 percent), but this could be a result of the wording of the question since the third choice was omitted (Table 8.13).

Community Response System

Table 8.14 presents the data for the question about "agencies you would turn to if you had a case of elder abuse." Again, there was a slight change in the wording between Survey I to Survey II. On the latter, the question was specially addressed to those agencies that had previously stated that they had not encountered a case, an exclusion which was not stated in the earlier wording. Whereas in Survey I, the Worcester respondents were more likely to include Elder Services (28.2 percent), Home Health Agencies (38.5 percent) and the Police (52.3 percent) along with the Model Project (which had a pre-existing Crisis Intervention Program) as agencies they would turn to (75.6 percent), by Survey II, the citations for these agencies had decreased leaving only the Model Project (68.4 percent) as the primary referral agency. Actual experience with cases of elder abuse/neglect ("name the agencies you turned to if you had a case of elder abuse/neglect") at the beginning of the grant period indicated that home health agencies were also selected by a sizable percentage of respondents (35.0 percent), although half the proportion of those who chose the Model Project (72.5 percent). By the end of the grant period, the Model Project was considered the chief source of assistance for abuse and neglect cases in the Worcester Area (82.6 percent) for those agencies answering the survey questionnaire (Table 8.15).

Since the Syracuse Model Project did not exist prior to the awarding of the AOA demonstration grant, it would be expected that there would be less likelihood of it being named as an agency "to turn to" early in the grant period compared to two years later. Table 8.15 shows that in Onondaga County the agencies were apt to turn most often to the State Agency [Adult Protective Services Department of Social Services (71.4 percent)] and the county Health Department (49.0 percent). Since the Adult Protective Services Unit of the Department of Social Services in New York State was mandated to handle adult cases, it is not surprising that when the community did encounter a case of elder abuse or neglect, it tended to refer to the state agency (APS) (68.0 percent). Two

TABLE 8.13 PROPORTION OF AGENCIES RESPONDING TO QUESTIONS ON AWARENESS OF ELDER ABUSE/NEGLECT IN SURVEY I AND SURVEY II

	Worcester Area		Onondaga County		Rhode Island	
	I n=86	II n=101	I n=55	II n=52	I n=71	II n=60
	%	%	%	%	%	%
a) Agency has known at least one case	40.7	48.5	49.1	57.7	53.5	60.0
b) Agency is aware, but has not encountered any cases.	55.8	31.7	47.8	30.8	40.9	26.7
c) Agency is not aware of elder abuse/neglect*	-	18.8	-	11.5	-	13.3
d) No answer	3.5	-	3.0	-	5.6	-

*This question only appeared on Survey II.

TABLE 8.14 COMMUNITY REFERRAL SYSTEM FOR CASES OF ELDER ABUSE/NEGLECT - AGENCIES "YOU WOULD TURN TO" WITH CASES OF ELDER ABUSE/NEGLECT - SURVEY I AND SURVEY II *

	Worcester Area		Onondaga County		Rhode Island	
	I	II	I	II	I	II
	n=78	n=38	n=47	n=15	n=64	n=19
	# %	# %	# %	# %	# %	# %
Boards of Health/Health Depts.	5(6.4)	2(5.3)	24(49.0)	1(6.7)	12(18.8)	-
Councils on Aging/AAA	11(14.1)	8(21.1)	16(32.7)	2(13.3)	-	-
Courts/Judicial	8(10.3)	1(2.6)	2(4.0)	-	1(1.6)	-
Elder Services	22(28.2)	6(15.8)	-	-	9(14.1)	3(15.8)
Health (Hospitals, Health Centers)	13(16.7)	4(10.5)	1(2.0)	-	3(4.7)	2(10.6)
Home Health Agenices	30(38.5)	7(18.4)	-	1(6.7)	4(6.3)	1(5.3)
Legal Services	12(15.4)	5(13.2)	5(10.2)	-	3(4.7)	-
Mental Health Services	11(14.1)	1(2.6)	5(10.2)	1(6.7)	10(15.6)	3(15.8)
MODEL PROJECT	58(75.6)	26(68.4)	9(18.4)	13(86.7)	52(81.2)	14(73.7)
Nursing Homes	-	-	-	-	-	1(5.3)
Physicians	1(1.3)	2(5.3)	-	-	1(1.6)	-
Police	40(52.3)	3(7.9)	5(10.2)	-	32(50.0)	3(15.8)
Religious/Church	4(5.1)	-	-	-	1(1.6)	-
Shelter	2(2.6)	1(2.6)	-	-	-	-
Social Services	8(10.3)	2(5.3)	5(10.2)	-	3(4.7)	2(10.5)
State Agencies	6(7.7)	1(2.6)	35(71.4)	3(20.0)	8(12.5)	8(42.1)
Within Agency Referral	-	6(15.8)	-	-	-	1(5.3)
Other	5(6.4)	1(2.6)	3(6.1)	1(6.7)	6(9.4)	-

---

*Wording of question in Survey I: Name the agencies that you would think of turning to with cases of elder abuse/neglect. Wording of question in Survey II: If you checked above (agency staff is aware of elder abuse/neglect but has not encountered specific cases), name the agencies you would think of turning to with cases of elder abuse/neglect. This difference in wording explains the decrease in number of respondents to this question in Survey II.

years later, the results are quite different. The majority of the respondents listed the Model Project (86.7 percent) as the agency "they would turn to" if they had a case of abuse or neglect (Table 8.14). For those who actually did have a case, both the Model Project (69.0 percent) and the APS were likely to be listed (69.0 percent) (Table 8.15).

According to Survey I findings the Rhode Island agencies "would have turned" most often to the Model Project (the Department of Elderly Affairs (81.2 percent)) and the Police (50.0 percent) (Table 8.14), but in reality they called upon the State Agencies (26.5 percent), the Police (26.5 percent) and the Model Project (58.8 percent) (Table 8.15). Two years later, the responses to the hypothetical situation tended to include the Model Project (81.2 percent) and the state agencies (42.1 percent) (Table 8.14). For a majority of those agencies having actual cases, the choice for referral was the Model Project for 86.1 percent of the respondents and next the mental health services, by 33.3 percent (Table 8.15).

Level of Service Needs

There appears to be a great similarity in the answers to the question on service needs in both surveys. According to Table 8.16, only a minority of the agencies responded to the question. Many different services were listed, but by five or less respondents, except for emergency shelter and respite care in the Worcester surveys, which were cited by ten and eight agencies respectively in Survey I and seven and eight of the 27 respondents in Survey II.

Procedure for Dealing with Elder Abuse/Neglect Cases

The responses in Survey I and II to the question regarding whether the agency had a specific procedure for dealing with elder abuse/neglect are very similar for all three Projects. About one third (34.6; 37.0 percent) replied affirmatively in the Worcester area; about one half of the Rhode Island agencies (52.3; 53.4 percent). The responses from Onondaga County agencies were different; 36.7 percent answered that they had a procedure for dealing with elder abuse cases compared to 45.1 percent in Survey II (Table 8.17).

B. Summary

In general, the mix of agencies reporting in Survey I and II in the three sites were quite similar even though about one-third of those who answered Survey I did not respond to Survey II and vice versa. Because of the problems in the wording of the question on the level of awareness, it is difficult to determine whether Survey II respondents were more aware of elder abuse than those who answered Survey I. The proportions tend to be a little higher. Even though a question about the numbers and types of cases of abuse and neglect seen by the agencies appeared on both surveys, comparisons could not be made because of ambiguity in the wording of the first survey.

TABLE 8.15 COMMUNITY REFERRAL SYSTEM FOR CASES OF ELDER ABUSE/NEGLECT - AGENCIES "YOU TURNED TO" WITH CASES OF ELDER ABUSE/NEGLECT - SURVEY I AND SURVEY II

	Worcester Area		Onondaga County		Rhode Island	
	I	II	I	II	I	II
	n=40	n=56	n=23	n=29	n=34	n=36
	# %	# %	# %	# %	# %	# %
Boards of Health/Health Depts.	2(5.0)	1(2.2)	7(28.0)	8(27.6)	-	-
Councils on Aging/AAA	5(12.5)	2(4.3)	1(4.0)	1(3.4)	-	-
Courts/Judicial	3(7.5)	-	1(4.0)	1(3.4)	-	1(2.8)
Elder Services	7(17.5)	10(21.7)	-	-	3(8.8)	4(11.1)
Health (Hospitals, Health Centers)	5(12.5)	3(6.5)	1(4.0)	-	2(5.9)	3(8.4)
Home Health Agencies	14(35.0)	7(15.2)	-	3(10.3)	2(5.9)	8(22.2)
Legal Services	9(22.5)	6(13.0)	4(16.0)	1(3.4)	1(3.0)	2(5.6)
Mental Health Services	7(17.5)	6(13.0)	2(8.0)	2(6.9)	8(23.5)	12(33.3)
MODEL PROJECT	29(72.5)	38(82.6)	4(16.0)	24(69.0)	20(58.8)	31(86.1)
Nursing Homes	-	1(2.2)	-	-	-	1(2.8)
Physicians	1(2.5)	2(4.3)	-	-	1(3.0)	1(2.8)
Police	5(12.5)	1(2.2)	1(4.0)	1(3.4)	9(26.5)	8(22.2)
Religious/Church	1(2.5)	1(2.2)	-	1(3.4)	3(5.9)	1(2.8)
Shelters	2(5.0)	3(6.5)	-	3(10.3)	-	1(2.8)
Social Service Agencies	4(10.0)	2(4.3)	-	5(17.2)	1(3.0)	4(11.1)
State Agencies	4(10.0)	2(4.3)	17(68.0)	24(69.0)	9(26.5)	9(27.8)
Within Agency Referral	-	2(4.3)	-	-	-	1(2.8)
Other	-	-	-	1(3.4)	4(11.8)	4(13.9)

TABLE 8.16 NUMBER OF AGENCIES RESPONDING TO QUESTION ON SERVICES WHICH ARE NEEDED TO HELP ELDER ABUSE/NEGLECT CASES BUT WHICH ARE NOT AVAILABLE IN SURVEY I AND SURVEY II

	Worcester Area		Onondaga County		Rhode Island	
	I n=27	II n=29	I n=14	II n=14	I n=22	II n=26
	#	#	#	#	#	#
Agency staff education	2	3	1	2	-	-
Advocacy	1	-	-	-	1	-
Companion services	3	-	-	-	1	-
Comprehensive/Coordinated service	1	3	-	2	4	4
Conservatoryship/Guardianship	3	3	-	3	2	-
Counseling/Stress management	1	3	1	2	5	2
Crisis intervention	-	2	1	-	1	3
Emergency shelter	7	10	2	4	5	5
Financial assistance	2	3	2	2	-	1
Foster homes	1	-	-	-	3	-
Home visits	-	-	1	-	3	5
Hot line	1	2	-	2	-	-
Housing arrangements	2	3	-	-	5	5
Legal services	2	3	2	-	2	-
Mandatory reporting	1	1	1	2	-	-
Medical/Psychiatric outreach	-	2	1	-	2	-
Nursing homes	1	-	-	-	-	-
Peer support	2	2	-	2	-	-
Protective services legislation	-	-	1	2	2	3
Public education	3	1	-	-	1	3
Reimbursement-easier	1	1	-	-	-	-
Respite facilities .	8	8	3	3	2	2
Staff workers	1	-	-	-	-	-
Other	3	-	3	-	6	1

TABLE 8.17 PROPORTION OF AGENCIES RESPONDING TO SURVEY I AND SURVEY II THAT HAVE SPECIFIC PROCEDURES FOR DEALING WITH CASES OF ELDER ABUSE/NEGLECT

	Worcester Area		Onondaga County		Rhode Island	
	I	II	I	II	I	II
	n=86	n=101	n=55	n=52	n=71	n=60
	%	%	%	%	%	%
Yes	34.6	37.0	36.7	45.1	52.3	53.4
No	65.8	63.0	63.3	54.9	47.8	46.6
No answer	8	1	7	1	4	2

In all three sites, the Model Projects are recognized as leading agencies for handling elder abuse and neglect cases by a large majority of community agencies, either those who had never had a case as well as those who had encountered one or more. Very little change was noted in the listing of service needs for the three localities from the beginning to the end of the grant period, perhaps, because of the adequate level of resources already available in these places; nor was there any change in the number of agencies with specific procedure for dealing with abuse and neglect. The implications of these findings as well as those of previous chapters will be discussed in Chapter Ten. Before presenting them, however, a final set of tasks undertaken by the Evaluation Team will be described in Chapter Nine that follows.

CHAPTER NINE

TRAINING PROGRAMS, CLIENT ASSESSMENT PROTOCOL AND MANUAL

The methodology and results for three tasks which were carried out under the supplementary grant awards made in Year 2 are presented below. They include the organization and the evaluation of two Training Programs, the development of a Client Assessment Instrument to be used by the protective services workers in Massachusetts, and the preparation of a Manual for use by human service workers.

I. Training Programs for Protective Service Workers

A. Method

Towards the close of the third year of the study, the Evaluation Team was given the responsibility for organizing and evaluating a program for training the staff of the newly established Massachusetts home care corporations' protective services units. A planning meeting was held with Mass. DEA personnel to determine the objectives, content and format. At that time it was agreed that the purpose would be to develop the clinical skills of the protective service workers; to provide information regarding the implementation of the protective services legislation; and to field test the Manual. Two social work consultants were engaged as trainers, one who had expertise in protective service work (program instructor) and a second for her skills in treating mental health problems in the elderly (guest instructor). The final curriculum was developed at a second meeting with the program instructor, several protective service workers, regional supervisors and DEA personnel in attendance. Two 2-day programs were scheduled, one in the eastern part of the state and the other, a week later, in the central area (Appendix II, Exhibit 5). A questionnaire was designed by the Team to evaluate the programs, the results of which are presented below (See Appendix I, Exhibit 9).

B. Results

Attendance at the first program averaged about 35. Twenty-four individuals completed the evaluation form: eight protective services staff workers; six individuals who serve as the "back-up" staff for the protective service worker; eight supervisors, and two others.
The participants were asked to rate the various components of the program with regard to quality, delivery and value of the material, and discussion time, noting whether "excellent," "satisfactory" or "unsatisfactory" (scored as 2-1-0). When considering all four characteristics, the most highly rated part of the program was "Principles and Dilemmas of Practice," followed by the "Role of the Protective Service Worker," both of which received mostly "excellent" marks. The least satisfactory component of the entire program was the Group Assignment which was con-

ducted during the lunch hour (Table 9.1). (Each table was given a list of "Attitudes and Skills" and asked to review and rank them as to their importance in work with abused and neglected elders).

Using a scale of 1 to 5 ("no" to "very much better"), the trainees were then requested to rate the effectiveness of the program in preparing them to handle specific issues. The highest score was given to "Worker Role;" the lowest, to "Case Transfer." The second highest rankings were given to "Worker Responsibility to Client (3.8) and "Goal Formation (3.8) while the next lowest scores were for "Case Closing" (2.2) and "Cultural Differences" (2.2) (Table 9.2).

Eight aspects of the program were also rated by the trainees, this time using a scoring system of 1 to 4 for "excellent to poor." The most highly rated segment was for the Program Instructor (1.2). When asked which topics they would like to see covered in future training, 18 persons provided information: alcoholism (9), family systems/intervention (7), mental health (4), worker liability (3), service plan (2), and case closing (2) (Table 9.3). Of the fourteen persons who added comments, all were a laudatory, particularly with respect to the Program Instructor. An example is:

> ...really enjoyed session. Helped to give an identity to the protective service work and offered much support as to this person's role. Certain segments could be expanded as a workshop because of the time restraints. This has been an excellent start in training and hope more of this quality and training will continue.
>
> ...good mix of didactic and experiential material. Case discussions helpful.

Except for a change in the luncheon guest speaker, the program for the second of the series was identical to the first. There were thirty-five individuals in attendance on an average for each of the two days, of whom twenty-eight completed the evaluation form: fifteen protective service workers, five of their alternates, seven supervisors, and one "other."

For this second group the most highly rated component of the program was that devoted to the "Role of the Protective Service Worker," in terms of quality, delivery and value of the material as well as the discussion time; second most highly ranked component was that devoted to "Principles and Dilemmas of Practice." The least satisfactory element was the lunchtime "Group Assignment" (Table 9.4).

Regarding the twenty-three issues covered in the program, the most highly rated were "Worker Role" given a score of 3.9; next was "Worker Responsibility to Client" (3.8). The lowest scored was "Case Transfer" (1.7) and "Cultural Differences" (1.9) (Table 9.1).

The overall rating of program arrangements, scored 1 to 4 (excellent to poor) ranged from 1.1 for the Program Instructor to 2.1 for the Food

TABLE 9.1 RATING OF CONTENT OF FIRST PROGRAM

	Quality	Delivery	Value	Discussion
Role of Protective Service Worker	1.9	1.9	1.8	1.4
Identification of the Abused Client	1.4	1.5	1.4	1.4
Group Assignmment	0.9	1.0	0.9	1.3
Principles and Dilemmas of Practice	1.9	1.8	1.8	1.7
Special Problems Facing the Protective Service Worker	1.7	1.8	1.7	1.6
Guest Speaker	1.7	1.8	1.7	1.6
The Service Plan	1.5	1.2	1.2	1.1

Scoring System: 2=excellent; 1=satisfactory; 0=unsatisfactory, n=24

TABLE 9.2 PARTICIPANTS' SCORES ON EFFECTIVENESS OF TRAINING IN PREPARING THEM TO HANDLE VARIOUS ISSUES RELATED TO ELDER ABUSE/NEGLECT CASES

Program Issues	First Program n=24	Second Program n=28
Abused Receptivity to Services	3.2	3.5
Abuser Receptivity to Services	3.0	3.4
Access to Abused/Family	3.1	3.4
Alcoholism and the Abuse Problem	2.7	3.0
Case Closing	2.2	2.3
Case Conference	2.9	2.7
Case Transfer	2.0	1.7
Confidentiality	2.8	2.4
Cultural Differences	2.2	1.9
Goal Formation	3.7	3.6
Mental Illness and the Abuse Problem	3.0	3.1
No Resolution of Problem	3.0	2.9
Problem Identification	3.6	3.8
Problem Prioritization	3.5	3.7
Service Coordination	3.1	2.7
Service Plan	3.2	3.7
Sexual Abuse	2.7	2.5
Team Approach	3.2	2.7
Worker Liability	2.6	2.5
Worker Responsibility to Client	3.8	3.8
Worker Responsibility to Other Workers	3.3	3.1
Worker Role	4.0	3.9
Worker Values	3.4	3.6

Scoring System: 1-5, "no" - "very much better"

(Table 9.3). In response to the request for topics for future programs, fourteen of the group answered, seven of whom listed legal issues, four, alcoholism; two family dynamics; two case work paractise; and one each on use of the assessment form, implementation of the regulations, and sexual abuse.

Thirteen persons gave additional comments; again they were very complimentary of the Program Instructor (12), for example:

> "Ms. Baily's presentation was one of the most useful and-practical trainings I have attended.

The more negative remarks included: more time should have been spent with the lawyers (guest speakers); little new information for me; information on mental health issues too basic; not concrete enough; and greater structure and organization needed.

C. Discussion

This training program was undertaken with three objectives in mind. However, by the time the program was implemented, it was clear that the focus had been placed on the one related to the clinical skills of the protective services worker. The primary instructor, who was rated very highly by the trainees, had placed her emphasis on clinical practice, particularly on the worker's role. Lack of time prevented her from covering the topics such as Case Closing, Case Transfer, and Cultural Differences, which might explain the lower ratings for these subjects. The second objective, to provide information regarding the protective services legislation received less attention, handled indirectly as part of the discussion of practice issues over the two day period. It was not possible to carry out the third objective, to field test the Manual for workers dealing with elder abuse and neglect, because the material was not completed. However, the persons responsible for preparing the handbook did attend the sessions to gather information on the issues of most importance to the most important practice issues. Overall, the programs can be considered to have succeeded in meeting some of the needs of the Protective Service workers and also in identifying issues for future training sessions.

II. Elder Abuse/Neglect Client Assessment Instrument

In December 1982, the Massachusetts General Court passed a mandatory reporting bill for elder abuse which required that certain mandated reporters (licensed health care providers, publicly employed social workers, family counselors, probation offices, and police), who have reasonable cause to believe that an elderly person is suffering from or has died as a result of abuse, immediately make a verbal report to the Massachusetts DEA and a written report within 48 hours. Abuse is defined as "an act or omission which results in serious physical or emotional injury to an elderly person" and includes non-accidental infliction of serious physical or emotional injury, coercion, intimidation, abandonment, and neglect.

TABLE 9.3 OVERALL RATING OF THE PROGRAM

	First Program n=24	Second Program n=28
Guest Instructor	1.5	1.4
Guest Speaker(s)	1.6	1.6
Food	1.7	2.1
Organization	1.5	1.5
Physical Facilities	1.4	1.9
Program Instructor	1.2	1.1
Style of Presentations	1.6	1.2
Use of Time	1.6	1.6

Scoring System: 1=4 "excellent to poor"

TABLE 9.4 RATING OF PROGRAM CONTENT BY PARTICIPANTS IN THE SECOND TRAINING PROGRAM

	Quality	Delivery	Value	Discussion Time
Role of Protective Service Worker	1.8	1.9	1.9	1.7
Identification of the Abused Client	1.5	1.6	1.7	1.6
Group Assignment	0.9	1.1	1.1	1.0
Principles and Dilemmas of Practice	1.8	1.8	1.8	1.7
Special Problems Facing the Protective Service Worker	1.5	1.6	1.7	1.5
Guest Speakers	1.6	1.6	1.7	1.2
The Service Plan	1.4	1.4	1.4	1.3

Scoring System: 2=excellent; 1=satisfactory; 0=unsatisfactory n=28

Since there was only six months from the time of the passage of the bill to the date of implementation (July 1, 1983), the Mass. DEA had to move very rapidly to develop the regulations and procedures. Within each of the home care corporations across the state, a "protective services unit" was established, staffed, in most instances, by a half-time social worker. A client assessment protocol was drafted, for temporary use until a newly designed Home Care Needs Assessment form for all clients was completed and the results of the Elder Abuse study available. The task of preparing a standard elder abuse/neglect assessment instrument was given to the Evaluation Team.

The objectives of this assignment were to create a form that would be compatible with the new Home Care instrument, would utilize the findings from the current research project as well as other studies in the literature, and would incorporate suggestions and comments from the protective service workers. The purpose of the new tool would be to lead the worker through the investigative process effectively and efficiently so that a determination could be made concerning the accuracy of the report, the nature of the problem, and the pathways for treatment.

As the first step toward accomplishing this task, the Team constructed a questionnaire for the protective service workers asking their opinion about the form currently in use, the length of time to complete it, and more specific information concerning its various sections and suggestions for improvement. The responses from workers indicated that the current instrument was cumbersome, repetitive, lacked space for narrative, difficult to fill out and in general was not very satisfactory. After a series of meetings with the DEA management staff and a review of the research findings, a draft was prepared and presented to the regional supervisors for their recommendations. This version which is being transmitted to DEA (See Appendix I, Exhibit 10), asks for evidence of serious physical and emotional abuse; and information concerning the abusive actions [Conflict Tactic Scale (Straus, 1979)], the physical environment, the abuser, client's need for protective intervention, the formal and informal supports utilized and available and the actions taken. If adopted, it is to be used in conjunction with the Home Care Needs Assessment form which includes the basic demographic, health, mental health, functional status, social participation and financial resource items. After field testing by several of the home care corporations, the final form will be distributed to all the agencies.

III. Manual

Early on in the grant period, it became obvious to the Model Project Directors and the Evaluation Team that the staff in their day-to-day activities were acquiring valuable experience and skills in handling cases of elder abuse and neglect which should be shared along with the evaluation findings. A review of the individual grant proposals, revealed that each one contained a reference to the dissemination of information about the identification and treatment of elder abuse and neglect clients. Rather than produce three reports on the topic, the Region I Administration on Aging office suggested that the Projects cooperate in the preparation of one Manual. A draft outline was prepared by the Massachusetts Project personnel and brought to a meeting of the Model Project Directors held in Albany in April, 1982. The concept of the Manual was approved by the Projects and the Administration on Aging and responsibility for its publication given to the Evaluation Team. To carry out the assignment, the Team hired the consulting firm of Centre Research, Inc. For the next two years, they worked closely with the Model Project and Evaluation staff, attended several "cluster" meetings, called for the specific purpose of discussing the Manual and communicated by mail or phone.

Although initially, the Manual was intended for two audiences, practitioners and policy makers, part way through the process, a decision was made by the group to focus on "how-to" and to cover the information for policy makers in the Final Report of the Evaluation Team. The content is drawn from case material furnished b the Model Projects as well as data collected in other evaluation procedures, including the assessments and reassessments of cases handled by the Model Projects, the survey of community agencies; the individual case reports abstracted from community agency records; and indepth interviews with Project Staff and selected community practitioners. Additional information was collected at the two training workshops conducted for Massachusetts protective servie workers, a number of whom also reviewed the draft and provided more case material. The final draft has been circulating for their comments and suggestions. the Table of Contents of the Manual is reprinted on page (Figure 10).

Each of the tasks just described are examples of how the findings from the Model Project study can be used to assist workers in the field of aging. The final Chapter returns to the initial objectives of the evaluation, summarizes the methodology and results, and then draws some conclusions for practice and policy.

Figure 10 Table of Contents of Manual*

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*University Center on Aging. *Working With Abused Elders: Assessment, Advocacy and Intervention*. Worcester, MA: University of Massachusetts Medical Center, 1984.

CHAPTER TEN

SUMMARY AND CONCLUSIONS

The Model Projects were established in 1980 with three year grants from the Administration on Aging (Title IV-C of the Older Americans Act) to demonstrate improved mechanisms for reporting, investigation, treatment and prevention of elder abuse and neglect. They included the Massachusetts Department of Elder Affairs, which selected one of its affiliated home care corporations, Elder Home Care Services of Worcester Area, Inc., to carry out the program; the Metropolitan Commission on Aging of Onondaga County, New York which contracted with Alliance Division of Catholic Charities of Syracuse; and the Rhode Island Department of Elderly Affairs which chose to operate the Model Project from within the state agency. A grant for evaluating the three projects was given to the University Center on Aging at the University of Massachusetts Medical Center. The adoption of a common set of definitions and assessment instruments by the three Projects made it possible to compare case loads, organizational structures and intervention processes.

The three Projects had as their primary purpose the provision of case work services to abused and neglected elderly and members of their families. The goal was to intervene in cases of maltreatment, to introduce services when appropriate, to counsel victims and relatives, and to help resolve conflicts between abusers and abused. In addition, the Model Projects were to function as coordinators among the service providers and to be a focal point for action by local agencies on behalf of abused clients. Finally, all three had the responsibility of educating the community about elder abuse and neglect.

It is the purpose of this final chapter to summarize the results presented in the preceeding pages as they relate to the three evaluation objectives of the Evaluation Plan:

- to determine the nature and extent* of elder abuse and neglect in a geographic area
- to assess the effectiveness of education/-training/information dissemination activities
- to measure the impact of the intervention model and to discuss its their implications for future research, practice and policy.

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*"Extent" was defined in terms of severity and number of manifestations of abuse and neglect and length of time the victim was mistreated. Determination of "prevalence" and "incidence" were beyond the scope of the evaluation study.

I. The Nature and Extent of Elder Abuse/Neglect

A. Case Assessments

From a review of earlier work on elder abuse and neglect, the sociological and psychological literature on family violence, and the gerontological research on family relations, five theoretical explanations for maltreatment of the elderly emerged and became the framework for this study. They included: 1) intra individual dynamics; 2) dependency; 3) external stress; and 4) social isolation. A fifth, intergenerational transmission, was not pursued because of the difficulty in collecting information on the personal history of the perpetrators.

The first phase of the evaluation was an analysis of the data from the 127 Individual Case Reports collected in the first community Survey (I): 62 completed by agencies in the Worcester area and 65 from the agencies in the city of Boston. The profile of the abused in this sample was of a female, seventy years or older, with physical and mental impairments, who was dependent on the abuser-caretaker for help with the activities of daily living and companionship. The person responsible for the abuse or neglect was usually a relative, frequently a son, often with a history of mental illness, alcohol abuse, or medical problems, who had become financially dependent on the elderly individual. In many cases, a web of interdependency and disability entrapped both the victim and the perpetrator, making it hard for them to seek or accept outside help or to consider separation. Based on the result of this study, a comprehensive assessment form was designed to obtain more detailed information about the relationship of the perpetrator and victim and the circumstances of their daily lives.

With these forms, data were collected on 328 cases by the three Model Projects, 59 in Worcester; 135, Syracuse; and 134 Rhode Island. These victims were also more likely to be female, about 75 years of age and living in a household with family members. The perpetrator was more often a male and younger in age. The most common form of maltreatment was psychological abuse which frequently accompanied other types of maltreatment. Generally, the victims had difficulties with the instrumental activities of daily living and were in a poor emotional health. Although they were dependent in large measure on their caretakers for their daily needs, financial management, transportation, and companionship, they were relatively independent in terms of financial resources. In contrast, the perpetrators were apt to be dependent on the victims for financial support. Their lives were stressful, both from the unrealistic demands of the abused/neglected person, changes in their own health status or from financial problems. The results also showed that the abuse/neglect was very threatening or life threatening for a large proportion of victims, ranging from one-third in Syracuse to three-quarters in Rhode Island, that the manifestations were multiple, and that the mistreatment had existed from one to two years, and in some cases, several decades.

When the 59 cases from the Worcester Project were compared with 49 non-abused/neglected cases from the same agency, one major difference was noted. A majority of the victimized elders resided in households with family members, whereas the greater proportion of the non-abused/neglected older persons lived alone. Both the victims and the perpetrators in the sample were found to have more problems with psychological and emotional health than their counterparts in the non-abuse/neglect situations. In spite of significantly greater functional and cognitive impairments, the abused/neglected elders did not appear to be more dependent than the non-abused/neglected group for most of their needs. Provocative behavior by victims coupled with unrealistic expectations and financial and medical problems of the perpetrators seemed to create a more stressful environment for the abused/neglected families than found in the non-abused/neglected sample, a situation which was further exacerbated in some instances by fewer and less frequent social contacts. Although these findings showed support for the theoretical arguments proposed at the initiation of this Evaluation, they did not shed much light on the dynamics of the problem. For greater understanding of the circumstances surrounding the phenomenon, a more discriminating procedure was necessary. In the next phase of the analysis, therefore, the focus was on specific types of abuse and neglect.

The relationship between the victim and the perpetrator was analyzed using the qualitative data provided by the social workers for 40 cases of physical abuse.* Four basic categories of abused elderly were identified. A few cases were grouped together because they represented long-standing patterns of family violence which had existed prior to the individual becoming "elderly." A small category involved those situations in which the abuser was so severely disturbed that the violence could be attributed to psychopathology. The third type, which comprise considerably more cases than the previous two, was marked by an increase in dependency, perhaps, the "last straw" in an already unstable situation. A final group involved abusers substantially dependent upon the abused.

The results of the earlier descriptive studies of the total sample and the above exploratory effort underscored the need to continue to refine the analyses. To this end, two more studies were conducted: the first examined the relationship of the various causal factors to the five discrete types of abuse and neglect; the second investigated in depth a select group of physical abuse cases.

The comparative study of the types of abuse and neglect clearly suggested that neglect was related to the dependency needs of the victims. The neglected elderly had significant problems with cognitive and physical functioning, which forced them to depend on their caretakers for many of the activities of daily living. They were likely to be more burdensome and stressful than victims of other forms of maltreatment because of a greater degee of impairment, advanced years and recent decline in mental health. In addition, perpetrators of passive neglect in the Syracuse sample had experienced stress in their own lives with the significant likelihood of having gone through a recent divorce or separation. A tendency towards social isolation, associated with loss, was also a factor in the Worcester cases of passive neglect which revealed a significant number of perpetrators without an emergency contact.

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*See Appendix II, Exhibit 4, Pillemer, Karl A. and Rosalie S. Wolf. "Understanding Domestic Violence Against the Elderly." Paper presented at the Annual Meeting of the Northeastern Gerontological Society, Newport, Rhode Island, May 1983.

The victims of psychological abuse were quite different. In marked contrast to cases of neglect, they were relatively impaired, cognitively and functionally, and more independent in meeting their daily needs, but more likely to be emotionally ill. Psychological abuse appears to be related to the mental health of the participants and the pathological interpersonal relationship which exists between them. The data from both the Worcester and Rhode Island cases indicated that the victims of psychological abuse were more likely to have poor mental health. Also, transactions between victims and perpetrators were likely to involve pathological behavior by the latter. A tendency at one site for perpetrators to have unrealistic expectations suggests that some psychological dependency on the elderly victim may exist. Indirectly, this finding was supported at a second site where a significant number of perpetrators of psychological abuse were provocative in their behavior towards their victims. There is the possibility that, at least in some cases of psychological abuse, perpetrators remain somewhat psychologicaly dependent on their victims and experience a perceived loss of power in their exchanges, as suggested by Finkelhor (1983).

Material abuse seems to be nearly exclusively related to the financial needs of perpetrators, although the determination of a statistically significant relationship in the Worcester cases was not possible because of the small number. The relative social isolation of victims may have been a contributing factor in the other two sites since the data show that Syracuse victims were more likely to have suffered recent losses in their social network and the Rhode Island victims tended to be unmarried. The perpetrators of material abuse were generally distant relatives or non-relatives, who were not emotionally involved with their victims, and appeared to be motivated by greed.

The two common denominators in cases of physical abuse in all three sites were the relatively poor mental and emotional status of the perpetrators and the shared living arrangements of victim and perpetrator. Interpersonal pathology was a common factor in these cases. In addition, the Syracuse victims of physical abuse were likely to be seen as a source of stress and the Worcester group, to display provocative behavior towards the perpetrators.

As a research effort, this phase of the evaluation had some inherent validity and reliability problems. Since the Project Staffs were responsible for completing the assessment forms, the information which they provided reflected their perception and program orientation.

Although attempts were made to insure intra-site reliability by limiting data collection for each Project to the two staff persons who were familiar with the cases, inter-site reliability was more difficult to achieve even though all Project staff took part in the cluster meetings which included discussion of the definitions and instruments. Of still more uncertain quality were the data for the non-abuse/neglect cases which were collected by the case managers who did not have the benefit of attending the Project conferences, although information was checked for accuracy of interpretation by the Worcester Program Director. In spite of the attention given to the design of the case assessment instrument, the questions of function, health, and social contacts (which had been based on an existing form used by the Massachusetts Department of Elder Affairs) were worded inappropriately in terms of "needs" rather than status so that some necessary information never was obtained.

Given the exploratory nature of this phase of the evaluation and the extensive number of variables, the interpretation of the results must be approached with caution. Because of the association among certain variables, statistical significance or non-significance may be spurious. An indication that an item is related to a specific type of abuse may be a result of the correlation of that variable with a second one, which is actually the causal agent. Because of multiple comparisons, the study also suffers from the problem of additivity of the type one error. The probability of making the wrong judgment with respect to the significance of a finding is a direct function of the number of tests which are applied. In other words, the greater the number of tests which are carried out, the more likely it is that a specific finding will be statistically significant due to chance. Notwithstanding these limitations, the result of this study support the relative importance of the variables that are included.

The research design for the indepth analysis of selected physical abuse cases which was conducted in the final year of the grant period corrected some of the deficiencies: clients were interviewed directly by the researcher; standardized scales were used to measure functional, health and social status; and a limited number of hypotheses were tested. The remarkable similaritiy in the findings for the physical abuse cases by the two research methods suggest that, despite the shortcomings of the case assessment procedure, the latter did produce results which could be substantiated. The summary of the indepth analysis is presented in the pages that follow.

B. Indepth Analysis of Physical Abuse Cases

Forty-two elderly victims, who were identified by the case workers in the three Model Projects as having been subjected to physical violence, and a matched non-abused control group were interviewed in their homes. As in the previous analysis, five potential causes of abuse were examined: intraindividual dynamics, dependency, external stress, social isolation and intergenerational transmission of violence. When the cases were compared with the controls on psychological factors, the abusers were much more likely to have mental or emotional problems, to abuse alcohol, and to have been hospitalized for psychiatric reasons. The results on the dependency criteria indicated that abused elders were not in poorer health or more functionally disabled than the control group; in fact, they were less disabled in a number of areas. The abuse group was not more dependent on their kin than the comparisons for assistance with activities of daily living, but the perpetrators were more likely to be dependent on their elderly victims than were the control relatives.

In regard to the external stress items, the findings are somewhat ambiguous. Of the life events used to measure stress, three were more likely to be associated with the abused families (someone moving in, someone leaving, and someone getting arrested). Rather than true external events, these actions could be attributed to the perpetrator and the abuse situation. No other stress items differentiated the two group. On three of the five social resources scales, the abuse cases scored more poorly than the comparison group. They had fewer overall contacts and were less satisfied with those they did have. Findings for intergenerational transmission of abuse were not significant. Abused elders did not report more physical punishment of children nor did they indicate that the perpetrator had been a victim of child abuse.

As this summary shows, two hypotheses received strong support: that elderly abusers were more likely to have mental or emotional problems, and that they tended to be more dependent on their relatives than the controls. One hypothesis received more limited support: abused clients were to a degree more isolated. However, they were as likely as the controls to have someone to help them in a crisis, and did not score significantly lower on the overall social resources rating scale. Two hypotheses, intergenerational transmission of violent behavior and external stress, were not supported by the data. The major findings, which are listed in Figure 11,also constitute a possible list of risk factors that may lead to an elder abuse situation. If these factors are supported by future research, the list (or a similar one) could be used as a screening instrument for potential abuse. More generally the findings can be employed, albeit speculatively, to diagram possible causative factors in elder abuse. Such a "path diagram" is presented in Figure 12. In this simple model, the abusers' mental and emotional difficulties, including alcohol abuse, lead in some cases directly to violence. They also cause the abuser to be dependent on the victim, which following the exchange paradigm, can also lead to physical abuse. Social isolation is a sort of "negative feedback loop" with dependency; the isolation of the elder keep others from intervening to change the abuser's position, but it is also a consequence of the abuser's behavior. Clearly, a more complicated causal model could be constructed but it would require multivariate statistical analyses of a larger sample to determine if such a "path" to abuse exists. This conceptualization, however, seems plausible based on the data and is supported by the qualitative findings reported here.

FIGURE 11 Major Findings

- Abusers have emotional problems that interfere a great deal with those activities.

- Abusers are more likely to have had a psychiatric hospitalization
- Abusers are more likely to be alcoholics.

- Victims are more likely to cite problems in relationships with abusers while abusers were children and teenagers.

- Victims are less likely to need help with ordinary housework.
- Victims are less likely to need help going out of dwelling.
- Victims are less likely to be judged "functionally vulnerable."
- Victims are less likely to need help with food shopping.

- Abusers are less likely to be primary helpers of victims.

- Victims are less likely to be financially dependent on abusers.

- Victims are less dependent overall on abusers (dependency scale).

- Abusers are more likely to depend on victims for housing.
- Abusers are more likely to depend on victims for household repair.
- Abusers are more likely to be financially dependent on victims.

- Abusers are more dependent overall on abused (dependency scale).

- Abusers are hurt more financially by a separation.

- Victims are less satisfied with social contacts.

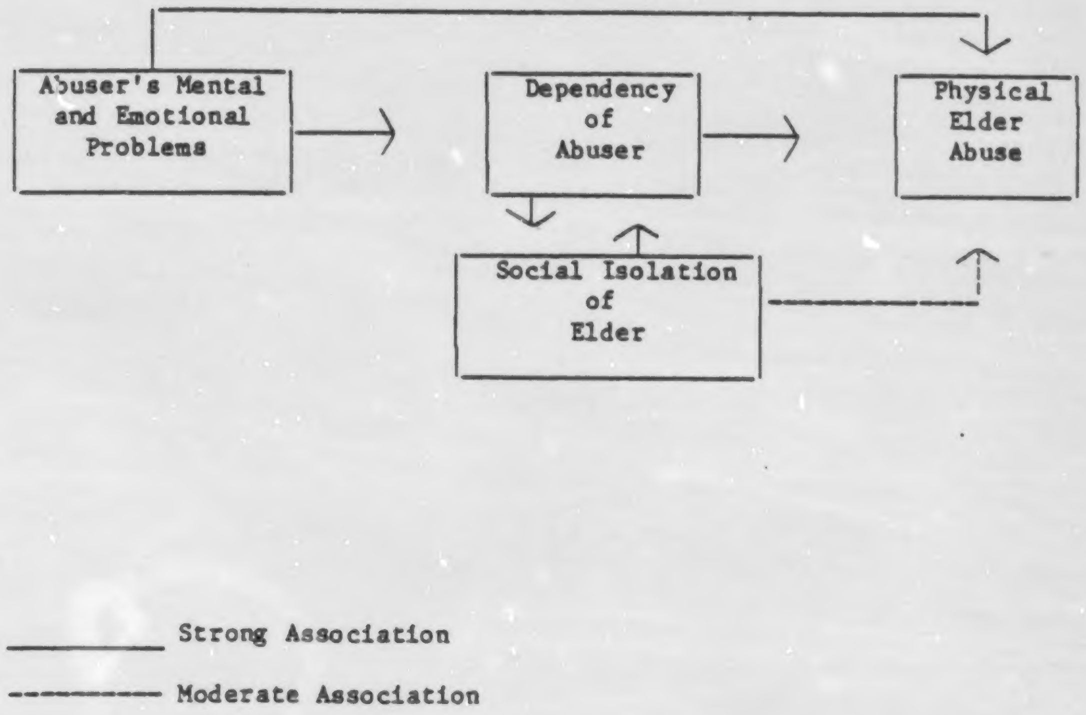
- Victims are more likely to report that abuser has a negative impact on their social relationships.

- No differences were found between groups in the presence of disease conditions.

- No differences were found between the groups in the amount of physical punishment received as a child.

- No differences were found in amount of external stress experienced.

Figure 12 Hypothetical Path Diagram for Physical Abuse


Abuser's Mental and Emotional Problems
Dependency of Abuser
Physical Elder Abuse
Social Isolation of Elder
Strong Association
Moderate Association

II. The Effectiveness of Education/Training/ Information Dissemination Activities

With the incorporation of the Syracuse and Rhode Island Projects in Year 01 into the Evaluation Plan, the researchable question posed in the initial applicaton, "What is the impact of the dissemination of information from the Elder Abuse Project in the state and nationally on the development of programs dealing with elderly abuse?" was modified and became the evaluation objective: to assess the effectiveness of education/ training/information dissemination activities. Two methods were employed to obtain the necessary data. The first was the inclusion of several questions on education/training in the survey of community agencies carried out during the third year of the grant. The second was the assessment by the Evaluation Team of specific educational programs sponsored by the Model Projects.*

According to the results of Survey II, about half of the community agencies that responded (somewhat less in the Worcester area and more in Rhode Island) had attended at least one program on elder abuse/neglect in the preceding two years, and the Model Projects had sponsored a large majority of them. Ratings for their programs were either "excellent" or "good." Inservice education was the most often mentioned format. Also, an evaluation of a one-day conference organized by the Syracuse Project to acquaint agency personnel with abuse/neglect, causes, therapeutic approaches and practice principles, indicated that the program was well received (Appendix II, Exhibit). Several areas for future sessions were suggested, including more facts about elder abuse, case studies, examples of protocols, models of intervention, and discussion of legal and ethical issues. Two training programs which focused on clinical skills for persons in the Massachusetts home care system working with abused/ neglectd elders were also given a very positive rating by the participants. They, too, requested more training especially in the areas of alcoholism, mental illness, and legal procedures.

It appears that from both the community survey and the program evaluation that the educational efforts of the Model Projects were successful. Not only did half of those agencies responding to the community survey not attend a program on the subject in the prior 24 months, but many groups, such as physicians, lawyers, and clergy (except for those in the Catholic Diocese of Syracuse), were not included in the survey or the training. In spite of the high case loads and limited staff, the Model Projects were able to sponsor a variety of educational programs, provide technical assistance and information, and conduct innumerable inservice programs. Nevertheless, the results indicate that there are many agencies and individuals in these localities working with older peoplethat did not benefit from the information and training.

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*More information about the specific educational activities carried on by the Model Projects can be found in their annual reports. Massachusetts Department of Elder Affairs (1984); Metropolitan Commission on Aging (1984); and Rhode Island Department of Elderly Affairs (1984).

In addition to the assessment of the above Model Project training and educational programs, the Evaluation Team arranged for the dissemination of findings through a) the publication of a manual for persons working with abused elders* and b) the organization of workshops and the presentation of papers at more than 20 national and regional meetings in the three year period (Appendix II, Exhibit 9 for listing). As a result of these efforts, more than 350 inquiries have been received for additional information about the Projects.

III. The Impact of the Intervention Models

When the Syracuse and Rhode Island Model Projects were integrated into the Evaluation Plan, the remaining four researchable questions, which had appeared in the original application to the Administration on Aging, were grouped under one evaluation objective: to measure the impact of the intervention model. Case resolution, community response and project replicability and efficiency were selected as criteria. The case assessment and re-assessment forms completed by the Project staff furnished the data to compare the status of the victims, perpetrators, and abuse/neglect situations at intake and at the close of the case; community surveys conducted two years apart provided statistics on community awareness and Project performance; and interviews with the Project and community agency personnel yielded information on the organizational models.

A. Case Resolution

All the Projects recorded a large decrease in the number of manifestations of abuse and neglect and their severity, and a significant reduction in the level of threat which they posed for the victim, between case intake and closure. They also made progress in reducing the degree of dependency of both the perpetrator and the victim regarding various instrumental activities of daily living and improving the quality of the relationship between the victim and the perpetrator. Syracuse and Rhode Island also noted significant improvement in the emotional state and self esteem of the victims and the level of stress on the perpetrators. One third of the Worcester cases were rated as either "not resolved" or resolved "a little" compared to one-quarter for Syracuse and Rhode Island, which was a significant difference.

For slightly less than half of the cases, the elimination of violence resulted from separation of the victim and the perpetrator through nursing home placement, death, hospitalization or relocation into new community residences. In fact, "change in living/social situation of the abused/neglected" was chosen from among several strategies by all three Project staff as having the most positive impact on case resolution. Guided by the principle that the least restrictive environment would be the most appropriate, the case workers did arrange for services to be brought into the homes of their clients or for temporary respite care, turning to nursing homes only if there was no other alternative. Nevertheless, one out of four of the Syracuse victims and one out of eight of the Worcester and Rhode Island groups were transfered to long-term care institutions.

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*University Center on Aging, Working With Abused Elders; Assessment, Advocacy and Intervention Worcester, MA: University of Massachusetts Medical Center, 1984.

There were situations, however, in which the victims preferred the possibility of further maltreatment than separation from the abusers to whom they felt obligated. Remaining in the family setting, no matter how violent, was for them a better alternative than the nursing home. There was, also, strong reluctance on the part of the elders to call the police for protection or to use legal or judicial means. Unless a judgment is made that one or both of the parties to the abuse is incompetent, the decision concerning treatment and placement is the elders'. Physicians often are unwilling to make a diagnosis of incompetency, which can be frustrating to the case workers who are trying to resolve the situation.

Given the multiplicity and complexity of the problems which the Project staff encountered in their cases, some of which involved very troubled and functionally disabled families, the number of cases that they were able to resolve and to help is praise worthy. The results in the three localities indicate improvement in a majority of cases. Although the major deterrent to case resolution was the reluctance of the victim and perpetrator to accept help, gaps in services and organizational issues were viewed as barriers for only a small proportion of cases. Change in living/social arrangements appeared to be the most successful strategy for resolving the cases; more often, this meant transfer to a nursing home. Yet, for more than half the cases, the residence remained the same. It was these situations which tested the skills of the staff, first in developing a trusting relationship with the family, second in assessing the situation, and finally in coordinating services for them.

B. Community Awareness

By the end of the grant period, slightly more than half of the agencies responding to the Survey (II) were aware of the problem of elder abuse and neglect and somewhat less than one-third were aware but had not encountered a case. A small proportion in all localities were not aware of such situations. These proportions are not very different from those of the first Survey (I) conducted at the beginning of the grant period. Because of the change in wording in the two questionnaires and the different group of respondents, no comparisons can be made as to the impact of the Model Projects in increasing community awareness. Fewer than one out of two of the community groups had specific procedures to deal with cases and of these, less than half were in writing; again proportions which were similar to those found in the earlier survey (I).

Over the two year period, however, there was a change in the community response system, with a larger proportion of agencies naming the Model Projects as the resource they would turn to or had turned to with cases of abuse/neglect. The social service and health agencies were more apt to refer directly to the Model Projects while the police, legal and mental health groups and some state agencies usually investigated the situation first and then referred, if the case warranted it. In both the Worcester area and state of Rhode Island, the Model Projects were the major referral units for elder abuse and neglect; in Syracuse it was a shared responsibility between the Model Project and the Adult Protective Services unit of the County Department of Social Services. The quality of the services provided by all Model Projects was rated as either excellent or good by the vast majority of community agencies that answered the survey (II), with special commendation for the promptness of the response.

Did the Model Projects have an effect on case findings and reporting? Although this question was not asked directly of community agencies, the survey forms did request information on the number and type of cases known to community agencies at the beginning of the grant period and two years later. Because of confusion about "cases" and definitions, these data from the first survey could not be used. When repeated in the second survey with more explicit directions, the numbers given by the community agencies were much higher in comparison to those reported by the Model Projects for the same time period. Whether this was due to several agencies reporting the same case or the fact that agencies do not refer all their cases cannot be determined. By law, the Rhode Island Model Project was to receive all reports of suspected abuse/neglect. The discrepancy in numbers suggest that community agencies may still be having difficulty in differentiating, identifying and referring domestic elder abuse/neglect cases.

Although all three Project were responsible for helping to establish services in their localities (e.g., Worcester organized a 24 hour hot line), the impact of this activity could not be documented from the survey data. Respondents to the first survey produced a long and varied list of service needs, but, except for emergency shelter and respite care, each one was mentioned only a few times. On the second survey, the question was answered by only one-quarter of the responding agencies, and again no resource was cited more than three or four times. From the perspective of the community agencies, there appeared to be no real service gaps, although in the case assessments, the Project staff in Worcester noted that they were hampered by scarcity of some services (particularly respite care); Syracuse, by non-reimbursement of certain services; and Rhode Island, by lack of protective services.

Whether the establishment of the Model Projects made a difference in the level of awareness of community agencies cannot be determined from this study. The results of the surveys at the beginning and end of the grant period indicate that about half of the community agencies were aware of the phenomenon and most others were aware but had not encountered a case. Also the results could not be used to document the influence of the Projects on case reporting or finding. Even carefully wording the survey question on number and type of cases so that there would be little possibility of misinterpretation did not produce valid information. Unless community agencies are asked to provide data on individual cases which can be used to verify the existence and type of abuse or neglect, the numerical counts are meaningless because of duplication of cases among agencies, confusion about definitions, and inclusion of suspected cases. The survey findings did however confirm the fact that by the end of the grant period the Model Projects were the major referral agencies for cases of elder abuse and neglect in each of the sites.

C. Model Replicability

A final consideration of the third evaluation objective concerned the organizational models. Two questions were raised in the original application: Is the Model replicable? Is it efficient? Efficiency as proposed in the initial application was to be operationalized in terms of the cost of resources, both services to the abuse/neglect cases and staff time, in comparison with non-abused/neglected clients. Shortly after the Syracuse and Rhode Island Projects joined the study, it became obvious that it would be extremely difficult to obtain such information from them since, unlike the Worcester Project; they did not have direct control over the services or enough staff time to devote to data collection of this type. The Worcester Project, during the first year of the grant, did assign the problem to a student intern who worked with the staff to collect the data. They divided the case load at that time into four categories based on complexity and the amount of time spent by the case manager. Two cases were selected at random from each category, and the total costs calculated. They ranged from $72.83 per month for category 1, the simplest cases to $700 for category 4, the cases with the heaviest needs. With the departure of the student, non-abuse care analysis could not be done (see Appendix I, Exhibit 11 for sample cost sheets), and consequently, the determination of the efficiency of the Projects, as initially defined, was not completed. In the later discussion of the Models, the client-staff ratio is used as a proxy for "efficiency."

It must be remembered that the Projects' although similar in goals, target population, staffing and operational definitions, represented various approaches to elder abuse/neglect intervention. The Worcester Project was located in an agency where the case workers had the authority to order a wide range of social services and thus has been designated as a "service brokerage" model for its clients. The Syracuse Project, on the other hand, functioned primarily as a coordinator of services supplied by other agencies and has been termed a "coordination model." It did however have direct control over a group of aides who worked with the most difficult cases. The Rhode Island Project ("mandatory reported model") had access to some direct services sponsored by the Department of Elder Affairs, but was also dependent on community agencies to assume responsibility for the cases once the situations had been investigated and the abuse alleviated. Consequently, a great deal of the Rhode Island staff efforts was spent in working with community agencies and coordinating care plans. Also, because of the mandatory reporting, the agency, unlike Worcester and Syracuse, was under pressure to respond to all calls within a certain time allotment.

Because of the variations in function and structure, the Project faced different problems in developing and implementing their programs. For example, the Worcester Project resolved an intra-agency problem by devising a plan of "co-management" so that the case managers in the agency could remain in charge of their abuse cases but also call on the Model Project staff for advice and direction. Similarly, the Rhode Island Project handled an intra-agency problem with its information and referral workers by (I and R) training all of them to accept elder abuse/ neglect reports rather than having all such calls referred to a separate I and R worker. All three Projects worked out formal and informal procedures for promoting interagency coordination. To facilitate the process, the Syracuse Project organized a "team" representing the relevant service providers for each case which met at intake and then as necessary to follow its progress. Rhode Island made use of key councils, groups of elder service providers in the local communities, that met regularly to discuss common cases. Both the Syracuse and Rhode Island Projects avoided conflict with their local Adult Protective Services units, which were also charged with responding to cases of abuse and neglect, by showing their willingness to take on the most difficult cases.

An analysis of the use of time by the Project staff indicated that the Worcester social worker spent about four times as long in direct service to clients (interviews, home visits, etc.) than did the social workers in the Syracuse and Rhode Island projects. This finding highlights the difference between the case management approach of the Worcester Project and the "assessment, coordination and referral" process utilized by the other two programs.

Did the more intensive attention which the Worcester staff gave to each case result in a more favorable client outcome? The results seem to indicate otherwise. As pointed out earlier, of the three groups, the Worcester Project staff had a significantly larger proportion of cases "unresolved" or resolved "a little" than the Syracuse or Rhode Island groups. Also they appeared to be less successful in changing the abuse situation than their counterparts since they noted "no change" in the level of stress or emotional state or problems for the perpetrators, aspects of the cases which the Syracuse and Rhode Island noted improvements, along with reduced hindrance from a variety of other barriers.

Were the Worcester cases more complicated and more time consuming? Although it would be difficult to compare the cases on these characteristics, the data analysis does indicate that the victims and perpetrators in the three Projects were not significantly different on objective factors. They did differ in the type of maltreatment which precipitated the report, with Rhode Island having more cases of physical abuse and fewer neglect, while the opposite was true for Worcester and Syracuse. No differences were found inthe proportion of psychological and material abuse or active neglect among all three. Since the passive neglect cases appeared to be resolved more easily compared to the physical abuse ones, the Rhode Island Project would be expected to have the largest proportion of "unresolved" cases; but, in actuality, the reverse was true. It does not appear, at least from the data collected in this study that the types of cases seen by the Worcester Project were significantly different than those seen by the other two Projects. If anything, since there was a smaller percentage of physical abuse cases than Rhode Island, the Worcester cases as a group should have shown a higher rate of cases resolved.

Did the Worcester group experience more barriers to delivery of services? Here, there does appear to be some differences. Of the three Projects, the Worcester staff noted that delivery of care was hindered by lack of available services in about one out of five cases compared to approximately one out of twenty in the Syracuse and Rhode Island sites. Also, the Syracuse and Rhode Island staff noted significant improvements in many barriers by the time the cases were closed, but Worcester did not. When the community agencies were asked to rate the performance of the Abuse Project, more than three quarters of the respondents in the Worcester area checked "excellent" for the Worcester Project compared to a about one-half for Syracuse and one-third for Rhode Island. Similarly, more than two-thirds of the agencies in the Worcester area stated that they were very satisfied with the degree of coordination and cooperation of services, but less than one-half for Syracuse and one-third for Rhode Island. The Worcester staff saw a much smaller number of clients which they monitored over a longer period, often after the abuse and neglect situation had appeared to be resolved. Their style of practice involved more intensive and extensive work with families, whereas Rhode Island used a short-term intervention and referral strategy, and Syracuse took a more middle of the road approach with greater likelihood of relocating clients into a new living arrangement. Rather than leading to greater of case resolution, the Worcester method seemed to make the staff more aware of the underlying issues involved in the case. Because of their deeper involvement in these family situations, the Worcester staff seemed to be less willing to label the cases as resolved, even though the immediate manifestations of abuse or neglect were gone. This interpretation may also explain why they found "receptivity of the abused and abuser" to be more of a hindrance than either of the other two project staffs. A more extended follow-up of cases might disclose whether in fact their view of the cases was a more accurate one than that of the Syracuse or Rhode Island staff.

Based on the above information, concerning client outcomes, case loads, coordination, and community response, how replicable are the three models? Are they appropriate only to their unique service environments or could their basic features be adopted by other agencies interested in providing protective services to abused/neglected clients?

The circumstances of both the Worcester and Rhode Island Projects are unique. Massachusetts, unlike any other state, has the extensive network of home care corporations which provide case management and social services to all frail elderly who meet the eligibility requirements (in FY84, 43,400 elders were served at a cost of $84 million in state funds). Prior to the demonstration, the Worcester agency had established a Crisis Intervention Program to handle the protective service cases. It was the opinion of the agency administration that these cases required more highly skilled case workers, smaller case loads and better trained homemakers than the usual clientele. This was not, however, the only model in use by home care corporations in Massachusetts. One of the tasks of this study (#4) was to compare two other programs, one in which the protective services component was contracted out to family service agencies; the other in which the abuse/neglect cases were assigned to the regular care managment staff as part of their case load.[*] After an analysis based on referral patterns, case coordination, service utilization, and management, the Worcester Model was judged the most efficient for the home care system and has since the end of the grant period been put into operation throughout the state.[**]

Because of the special nature of the home care agencies, it would not be realistic to recommend the Worcester Project as a national model for dealing with cases of abuse and neglect over the other two Model Projects. Although it was rated highly for performance and coordination by the community, its client-staff ratio was considerably smaller than the other two programs, and, at least, in the perception of the Project staff, slightly less successful in resolving the cases.

Rhode Island also represents a special model. As part of a state agency which is both a state unit on aging and an area agency on aging, it did have considerable leverage in working with other state agencies and the local communities. According to the response from community agencies, however, it was less effective than either of the other two projects in coordination and performance. The high client staff ratio, the mandate to respond to all of reports as well as the normal tension which exists between the state and local groups may explain these results.

Of the three Projects, the Syracuse model stands out as the easiest to replicate. Its record, regarding case load and resolution, was similar to that of the Rhode Island Project, but is efforts at coordination of services were viewed more positively by community agencies. Using the team conference as a coordination strategy, the Syracuse project was able to involve local service providers in the case management process and the local Adult Protective Service unit (mandated by the state to respond to reports of elder abuse and neglect) in a way which avoided issues of territoriality and conflict. Although it did not have control over a range of services as did the Worcester Project, it did employ a group of aides who assist in coordination and communication among the staff, clients, and service providers. Because no special sponsorship is needed, such as a home care corporation or a state or area agency on aging, any human service organization can adopt the program. This flexibility as well as the success in case resolution, the high case-staff ratio, and the effectiveness in coordination make the Syracuse project a particularly attractive model for replication.

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[*] See Appendix II Exhibit 2 Pillemer, Karl A. and Rosalie S. Wolf. "Organizational Assessment of the Delivery of Protective Services to Abused and Neglected Elders at Two Home Care Corporations." (Worcester: University Center on Aging, University of Massachusetts Medical Center, January, 1983).

[**] In the third year of the grant, elder abuse legislation was passed by the Massachusetts General Court and reporting of elder abuse/neglect cases was made mandatory. There is now in each home care corporation a protective service specialist. Unlike some states, the Massachusetts Adult Protective Services division of the Department of Public Welfare handles clients under 60. Responsibility for those 60 years and over has been given to the Department of Elder Affairs.

IV. Implications and Future Directions

This evaluation, which began with a plan to assess the activities of one Model Project, grew over the three year period to include fourteen different tasks encompassing three Model Projects (during the first year, four, Boston); assessment and reassessment of 328 abuse/neglect cases; two community surveys each with responses from 212 agencies; the production of a manual for persons working with abused/neglected elders; implementation and evaluation of two training session; analysis of two other organizational models for delivery of protective services in Massachusetts; an indepth analysis of physical abuse cases; and the design of an instrument for identifying abuse/ neglect. Additionally, the Evaluation Team assumed primary responsibility for dissemination of information about the Project regionally and nationally.

In the final segment of this Chapter, the implication of the major findings regarding the nature of elder abuse/neglect, education-training activities, and the organizational models will be presented. A discussion of the significance of the results of the analyses of the physical abuse cases for the study of elder abuse and for the theories of the family in later life will follow. The Chapter ends with some thoughts on future research, practice and policy directions.

A. Implications for Practice

The most important finding of the evaluation study is that elder abuse/neglect is multi-dimensional. It cannot be described by a single set of factors or explained by one theory. That each type of elder abuse had distinctive characteristics, which fit one theoretical model better than another, may not be surprising given the complexity of the circumstances surrounding these cases. Many factors are at play:. the physical and psycho-social status of the protagonists, family dynamics, the environment, the culture in which the individuals were raised, and the economic situation. Yet, when searching for a theoretical explanation for elder abuse and neglect, sociologists and gerontologists have tended to concentrate on one paradigm. The value of acknowledging the differences of each type of abuse cannot be underestimated. A better understanding of the possible causal factors on the part of practitioners and program planners will help in the development of preventive and intervention strategies and, particularly in identification of persons at risk.

The study shows that psychopathology is very evident in cases of psychological abuse and to a lesser degree, physical abuse. Contrary to the minor role which it is given in the family violence literature, psycho-pathology appears here to be a major explanatory variable for elder abuse. Whether this is due to the fact that the cases seen by agencies are more likely to be psychopathological in nature than those which exist in the general community cannot be determined in this study. It does suggest, however, the need to carry out community based population surveys not only to determine the incidence but to learn more about the phenomenon and its variations. If indeed psychopathology is as an important risk factor as it seems and not the results of a methodological bias, then the origins of elder abuse by adult children may be quite different than that of spouse or child abuse.

The results of the evaluative research also suggest that the relationship of dependency to elder abuse/neglect found in the gerontological literature needs re-examination. The portrait of the victim as a very old, increasingly functionally disabled woman, totally dependent on an overburdened, neglectful or abusive adult child is characteristic of neglect in this study, but not abuse. In cases of physical, psychological and material abuse, dependency takes on another form. Not only is the victim dependent on the perpetrator but perpetrator is dependent on victim. Given these findings, exchange theory may be an appropriate conceptual framework in which to study forms of abuse. The exchange paradigm suggests that as dependencies increase, the cost of the relationship to the caregiver become greater, the rewards diminish, and the exchange is perceived as unfair. The perpetrator acts out of a sense of powerlessness.

Of lesser influence as a theoretical explanations are the sociological factors of external stress and isolation. Although present in the situations of the various types of abuse/neglect, they seem to exacerbate the situations rather than cause them directly. Again, these results may be byproducts of the research design and certainly should be investigated further.

Two other points should be made concerning the nature of elder abuse and neglect, based on the Model Project case assessments. First, there is no doubt that spouse abuse exists among the elderly. Those cases in which the maltreatment has been going on for decades were essentially spouse abuse. Intervention in these instances may be more successful if the situation was viewed from the perspective of spouse, rather than elderly abuse. More will be said about this later. Second, the material abuse situations are interestingly different from other types of abuse and neglect. The perpetrator is likely to be a non-relative, to live in a separate household and less psychologically motivatied. Better understanding of material abuse and how to prevent it may come from viewing it in terms of a criminal act rather than part of family violence, even if a family member is involved.

Certainly, the findings of the study need to be substantiated in more rigorous research designs. Taking into consideration that there are distinctive characteristics associated with each form of abuse and neglect, that the victim and perpetrator may be dependent on one another, and that spouse abuse exists in elderly household will be helpful in designing strategies for prevention and intervention. These points will be further elaborated in the final pages of this section.

It is important that valid and reliable information about elder abuse and neglect be made available to people in the aging field as well as others who may in some way be involved in the problem. So much of what has appeared in print in the past five years has been based on early studies which represented relatively few cases and which, more seriously, were methodologically flawed. Almost every national, regional and state meeting dealing with problems of the aged has included at least one session about elder abuse, but the audiences tend to be relatively small were limited dissemination of materials. Even the concerted efforts made by the Model Projects reached only a portion of the community and human service providers.

There is now a network of agencies in most states established to respond to reports of abuse and neglect at the local level. The likelihood is that before long, most if not all the states will have laws governing the reporting and investigating of elder abuse situations programs, service requirements, immunity and competency. Many social and legal services, health and mental health facilities, the police, courts, and churches are, or will be, involved. For all of these groups, education and training about the issues involved in elder abuse and neglect will be vital.

Several implications for practice can be drawn from the analysis of the Model Projects and their impact in the community. Important elements in the success of any program are the organizational structure, the staff and the environment. To work with elder abuse and neglect cases, the organization must a) be able to coordinate services and agencies; b) be flexible in the approach to practice; c) be creative in overcoming barriers to the delivery of services; and d) be prepared to fail. The staff must be well trained, patient, and persistent. A friendly, community environment with a well-organized human service system will enable the project to develop the linkages which are required for working with the complex abuse/neglect cases. Both the Worcester area and Onondago County are such communities. Some of the difficulties in coordination in the Rhode Island site, cited by the community agency representatives, may have been due to the fact that Rhode Island Project did not have such a highly organized environment in which to operate.

B. Implications for the Study of Elder Abuse

Two major themes have emerged from the physical abuse study. The first is a general one: support was found for theories that relate elder abuse to problems in the individual, and little or limited support for "social structural" causes of the phenomenon. The second point is really a subset of the first: the notion that physical abuse results from caregiver strain found little evidence in this study. As will be discussed below, the second finding has important implications for gerontological theory.

To a sociologist, the dearth of findings that support social structural approaches to the causation of elder abuse may be disturbing. The evidence is consistent, however. The cycle of violence theory was not supported here, that is, there did not appear to be a connection in this sample between physical abuse experienced as a child and commiting acts of elder abuse. It was noted in an earlier chapter that the existence of such a cycle would lend creedence to social learning theory, which holds that the family is the "cradle of violence." From the evidence, the family life of the elder abuser does not appear to have been unusually violent. This socio-cultural theory, then does not appear to offer the explanatory power it has been found to have with other forms of family violence. It was also found that external stress played little or no role in the abuse cases. The abused elders did not have lower incomes, nor is chronic economic stress indicated as a cause of violence. Similarly, external stressors were not found to add to the risk of abuse. What is left is the image of an impaired, dependent perpetrator who uses physical violence to obtain money or goods, or to compensate for a lack of power in his or her relationship with the victim.

It is interesting to point out that this portrait of the perpetrator was substantiated by variables that were originally intended to test entirely different aspects of the abuse situation. For example, three stressful events were more likely to happen to the abuse victims; however, these were all related to the behavior of the perpetrator. Similarly, abused elders were more isolated than the controls, but this was in large part due to the aberrant and disruptive behavior of the abuser. The findings presented in this report consistently support a focus on the abuser and his or her troubles. This is exemplified by the issue of dependency. It has become fashionable to characterize families of the elderly as willing, responsible caregivers. This is largely due to research on caregiving, but also in part because families have come to be seen as key components in reducing public costs of long-term care. The resulting view taken by many persons interested in elder abuse was one that tended to blame the victim. The elderly, it was held, are hard to care for. They create stress for their relatives, who in turn get angry, lose control, and strike them.

If this scenario is rejected as the principle way in which elder abuse occurs, what is left? An old person who holds a strong set of beliefs about family responsibilities, and who cannot refuse care and support to a dependent relative. The costs of this decision run high, but are counter balanced by some "negative" rewards: not having to worry about the relative; not feeling guilty for abandoning him or her; not to an extent being lonely. Robert Frost's dictim.."Home is where, when you go there, they have to take you in".. appears to be in force in the minds of the abused elders as long as the abuser is living with them, they have some possibility of turning the situation for the better. The decision to force the relative to leave means abandoning him or her. It also means admitting failure as a parent or spouse, and closing one of the few intimate contacts that old age has left them. These aspects of the abuse situation should not be overemphasized. But one important point stands out for the study of elder abuse. Accepted notions about the responsible behavior of relatives of the elderly must be re-examined. In particular, elder abuse researchers, using strategies outlined in the following section, must begin to view the phenomenon as domestic violence, rather than "caregiver" violence. Certainly, it is not necessary to return to theories of a "criminal" type to explain deviant behavior such as elder abuse. The possibility, however, that characteristics of the abuser may be strongly associated with violence against the elderly must be considered.

C. Implications for Family Gerontology

Gerontological theory is not well developed, a situation which, to even a greater degree, is true of family gerontology. As noted earlier, exchange theory has been employed with some profitable results. Certainly, the study supports an exchange theory paradigm, the empirical results were interpretable by using the vocabulary of costs and rewards, and in particular by the use of the concept of power. It has been argued here that abusers behave violently to compensate for a lack or loss of power. Due to the elders' somewhat increased vulnerability (which in some areas is equal to that of the control group), he or she is unlikely to retaliate physically. Increased social isolation also makes intervention by others unlikely. Thus, the violence incurs few costs to the abuser.

An exchange perspective, then is very useful in understanding elder abuse. However, this conclusion is not compatible with another assertion: that conflict theory should be extended to the aging family. Although this study has not been able to determine whether it is correct, as Mannheim asserts, that the generations see the world differently, it has uncovered families in which conflict is rife. Sometimes, this conflict appears as overt violence, and at others as extreme verbal aggression. In general, patterns similar to those observed by Hartmann (1981) seem to exist. Conflict goes on over scarce resources, such as money or power. It is not known to what extent such processes go on in non-abusive families of the elderly. The conflict model would be a useful departure point for future research efforts.

There is also much need for the extension of another type of theory to the aging family. As the evidence mounts, elder abuse comes more and more to look like another social problems: violence against women carried out predominantly by men. Much feminist research (Walker, 1984) has placed spouse abuse in the context of the patriarchal nature of American society, and has insisted that male dominance be seen as a causitive factor. In this study, all but three of the victims were woman, and the three men were all abused by sons. Woman in the sample were more likely to be abused by sons, husbands or brothers than by daughter or daughters-in-law. Future researchers should attempt to extend feminist principles to the area of elder abuse. This would not only aid us in understanding maltreatment of the elderly, but would also provide an important new testing ground for feminist theory.

In essence, these proposals for greater use of conflict and feminist theory point to the same thing: researchers in family gerontology should move beyond the consensus model that has thus far guided research in this area, beyond evidence such as physical proximity of kin and frequency of visitation to studies of the quality of relationships. The notion that the kin of the elderly always approach them with the best interventions may not be always true. Conflict, rather than consensus, may be the main dynamic in the aging relationships.

D. Future Directions

Beyond their implications regarding elder abuse and family gerontology theory, the results of the investigations conducted as part of the evaluation of the three Model Projects can also be used to set an agenda for future research and for informed policy decisions related to intervention.

Research Issues

This project has provided a number of useful insights of value for researchers.

1. Investigators can confidently design studies based on direct interviews with abused elders. They will talk, and often at great length about the maltreatment. Although there may be cases in which the researcher specifically wants to study professionals, for example, he or she may wish to understand professional labeling of abuse, there can be no further justification for relying more on professional accounts of abuse, rather than those of the victims.

2. Future studies must move away from agency samples to general population surveys. An incidence survey of the community is greatly needed to learn the magnitude of the problem and to provide a much more complete picture of conflict and violence. The results of studies of other forms of family violence indicate that the cases that reach an agency tend to be the most severe.

3. The importance of a control group design cannot be over-emphasized. It was only through this methodology that certain characteristics of the victims were identified; for instance, the finding that physically abused elders are less impaired than non-abused elders. Such comparison studies need to be replicated.

4. Researchers in this field should attempt to interview abusers. A major disappointment in the physical abuse study was the failure to obtain an abuser sample. The accounts of perpetrators may differ greatly from those of victims. This additional perspective is needed to understand elder abuse.

5. Studies should focus to a greater degree than was done here on the consequences of abuse. What effects does being an elder abuse vic-

tim have on an individual? "Learned helplessness" has been found to be a consequence of ongoing spouse abuse (Walker, 1977-78; 1984). Does this hold true for abused elders? This study focused on the causes of maltreatment: others should concentrate on the sequelae of elder abuse.

6. Investigators should pay more attention to the context of abusive acts than was done here. Does an argument precede abuse? Has one or both persons been drinking prior to the incident? Are others ever present? More specifics regarding the circumstances in which domestic violence against the elderly occurs are necessary.

7. Another topic for exploration is why abusive children come to live with their parents. In this study, three daughters had returned to their mothers' homes in the wake of an abusive marital relationship. How frequently does this occur? In other instances, the child has severe emotional problems, and could not live independently. Since less than one in ten elderly persons reside with their children, it may be helpful to understand how these shared living arrangements came about.

8. The findings, particularly of the physical abuse cases, raise the question of parent-child relationships and child rearing practices. So many of the case studies in which the adult child was dependent on the parent, also revealed a parent who did not "let go." What can parents do as the child is growing up to insure that the kind of pathological interdependency illustrated here is avoided. The study of elder abuse can shed light beyond the specific phenomenon and can increase understanding of family relationships in a more general way.

9. The question of "case resolution" should be studied further. A simple definition of "alleviation or elimination of maltreatment" which was utilized in this project may not be adequate, especially when the victim does not wish to be separated from the perpetrator. A more valid and reliable measure for such cases may be necessary.

10. A follow-up study of the Model Project cases to compare the long-range effectiveness of their approaches would be useful. Did the more intensive and extensive involvement of the Worcester staff lead to more permanent case resolution than the procedures utilized by the other two Projects?

11. Some attention should be given to the abused/neglected situations which required a change in living arrangements. Under what circumstances is it necessary to separate the victim and perpetrator. Why, for instance, did the Syracuse Project place more victims in nursing homes?

12. The findings of the study produced a series of risk factors which have formed the basis for the design of an instrument for the identification and assessment of abuse/neglect victims. Additional studies are necessary to test their validity and reliability.

Practice Issues

Two types of issues need to be discussed here; those which relate to service planning for abused elders and those which relate to social policy towards the aged in a larger sense. In considering the first area, it is important to recall one of the major findings of the indepth physical abuse study: the hypothesis that the dependency of the victim on the perpetrator was a major cause of elder abuse was not supported. The combined weight of the quantitative and qualitative evidence reported here show a strong association between the dependency of the abuser and maltreatment. The victims perceived themselves as being on the losing end of the exchange. Previous research which has attributed abuse to the demands of the older individual has tended to blame the victim; the findings reported here suggest refocusing on the perpetrator.

An emphasis on the problems of the abuser would have important implications for service planning. Many states are developing protective services programs to intervene in cases of elder abuse, and some (32 to date) have instituted mandatory reporting laws. In order to implement such statutes, the protective service function must be expanded even further. A dilemma facing every new program is that of case identification. Who are the most vulnerable elderly? Previous attempts to identify older persons at high risk of abuse have been colored by the assumption that the dependency of the victim causes maltreatment. If the findings reported here are substantiated by future research, an additional risk category can be identified; situations in which relatives (especially children) live as dependents with the older person. Elder abuse workers and other professionals should pay special attention to such cases.

Based on the hypothesis that elderly dependency leads to abuse, supportive services to caregivers have been offered, such as self help groups. In many cases of elder abuse, an attempt is made to introduce home care services, such as house cleaning and meal preparation, to receive the "burden" of caregiving. Although such services may play a role in preventing or ameliorating abuse situations, the present study shows a need for other services as well. Exchange theory offers an approach to intervention. Either the rewards of reducing dependency on the elder can be increased or the costs of abusing the victim can be heightened. To achieve the former goal, unhealthy dependence of an older person could be reduced through psychotherapy, employment counseling, and financial support for the abuser while he or she establishes an independent household. In some case the change in living situation may be nursing home placement for a dependent, abusive spouse.

The costs of abusing an elderly person can be raised in a variety of ways. One option is to increase social support for the elderly. For example, the battered woman's movement as noted earlier, has made much use of self help groups. One important component of such groups has been consciousness raising. Battered woman and their advocates have gone to great lengths to convey to group members that they have a right to be free from violence, and that its use cannot be justified. [illegible] women then convey this message to their spouses. With support, they become able to say: "I will not take this anymore!" It is possible that such an approach directed toward the elderly might have similar usefulness.

Further, attempts could be made to increase the presence of outsiders in homes where abuse occurs. Lack of social support was found to be a significant factor in this study. Strengthening the informal support network would increase the costs of abusive behavior to the perpetrator, for interested outsiders would negatively sanction the behavior. Informal support networks can be built up through volunteers, creating linkages in neigborhoods, and case management programs (Biegel, et al., 1984).

Still another possibility, "safe houses" and emergency shelters, could be used for the elderly. Spouse abuse workers have relied heavily on such locations to protect abused women. This model presumes that after escaping from the abuser, the victim can either begin to live independently, or can return to the abuser, who is now aware that she will not tolerate abuse. The realization that the victim can and will leave adds another cost for abusive behavior.

A final alternative is legal action. Clearly, when elder abuse was conceived of as occuring because of caregiver strain, involving the police rarely semed necessary. In the new conceptualization put forth here, elder physical abuse is seen as having parallels to spouse abuse; relatively independent people sharing a residence with the physically stronger one victimizing the weaker. In fact, legal action may be especially appropriate in elder abuse cases, as so many seem to have an element of financial exploitation.

Sherman and Berk (1984) provide important evidence that police intervention may reduce the incidence of domestic violence. In a controlled experiment, they found that arrest was the most effective method to prevent further episodes of wife abuse. If the traditional police reluctance to get involved in domestic violence can be overcome, such law enforcement activity in elder abuse may also be effective. The cost of being arrested for many would greatly outweigh the rewards obtained from abusive behavior.

It is clear then that a refocussing way from the stressed caregiver model of abuse leads to a new set of possible remedies. When domestic violence against the elderly is seen to be at least partially or equally the problem of the abuser, some combination of the above service programs appears to be indicated. Advocacy for the victim, coupled with attempts to change the life situation of the abuser, and legal action if necessary, may be the key to intervening in elder abuse cases.

Policy Issues

Of the various groups which are involved in treating abuse cases (e.g., hospital teams, legal services, home health agencies, mental health centers, etc.), the social service agency appears to be the most suitable for handling the case management functions and conducting the many services which are often required. A family systems approach may be the most successful since abuse/neglect situations involve various family members within a household: spouses, children or grandchildren, or siblings or other relatives. Most of the states with elder abuse protection laws have elected to place their protective services units within departments of social services rather than in the state units on aging. With this arrangement there is the possibility that the older adults will not receive adequate attention. On the other hand, placing an elder abuse program within the aging network may require that the organization invest time and resources in working with non-elderly family members. These issues raise the question of the appropriateness of an age-segregated versus age-integrated service delivery system.

Another social policy issue is one that was raised at the outset of this report: the question of the limits of family responsibility for the elderly. Many relatives, caring for severely impaired elderly relatives, do so willingly and competently. In fact, a number of the comparison group elders in the physical abuse study had serious problems with activities of daily living and required much help for their families. However, the data on the abuse group provide a picture of families in trouble. In a few cases, the caregiver is under tremendous stress, so much so that he or she becomes violent. In the majority of cases, the relative who resides with the elderly person has a variety of personal difficulties, which makes him or her unlikely to be responsible caretakers, should the older person require it.

Federal and state attempts to shift even more caregiving burden to relatives should be resisted. Such plans range from providing a tax credit or direct payment to persons caring for aged relatives in their home, to actually making children liable for the costs of their parents' nursing home care. Based on these data, such a shifting of responsibility should be done only with great caution. Put simply, many family members do not have the ability to care for frail, impaired older persons. It is difficult to imagine many of the abusers in this study doing so. Policies that place the elderly in the hands of such individuals must be pursued with care. Certainly, concommitant with any such steps must be the provision of protective services. As part of that effort, new and better ways of screening and identifying potentially abusive households must be developed. It is for this reason, if not for the many others put forth here, that continued research on the abuse of elderly should have a high priority in social gerontology.

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ELDER ABUSE AND NEGLECT: FINAL REPORT FROM THREE MODEL PROJECTS

APPENDIX I

and

APPENDIX II

Rosalie S. Wolf
Michael A. Godkin
Karl A. Pillemer

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Worcester, Massachusetts

ELDER ABUSE AND NEGLECT: FINAL REPORT FROM THREE MODEL PROJECTS

Rosalie S. Wolf
Michael A. Godkin
Karl A. Pillemer

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APPENDIX I

December, 1984
University Center on Aging
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, Massachusetts 01605

CG 018083

APPENDIX I

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EXHIBIT 1

Agency Name:

Case #/Name Code: ____________________ Case Manager: ____________

Dates during which data were collected: ____________
____

ELDER ABUSE/NEGLECT: CASE ASSESSMENT

For the initial assessment attempt to reconstruct the abuse/neglect situation as it existed just prior to intervention by your agency. This task may take a few weeks while a relationship with the client is developed and/or could require consultation with agency personnel who referred the client to you.

I. KEY FACTS - CLIENTS

1. Name: ____________________ 2. Telephone: ____________

3. Address: ____________________ 4. Soc. Sec. #: ____________

City/Town: ____________________ Zip Code: ____________

5. Primary M.D.: ____________________ Telephone: ____________

6. Other M.D.s: ____________________ Telephone: ____________

____________________ ____________

7. Hospital/Clinic: ____________________ Telephone: ____________

8. VNA Nurse: ____________________ Telephone: ____________

9. Emergency Contacts:

	Full Name	Address	Tel.	Relationship to Client
a.				
b.				

10. Date of Birth: ____________

11. Marital Status:
____ Single ____ Married ____ Widowed ____ Divorced/Separated

______ Years in this status

12. Household Composition: ____ Lives Alone ____ Lives with Other(s),

State Relationship(s): ______________________________

Specify household owner and years client lives in present dwelling:

____

13. If client does not speak or understand English, please note primary language: ________________________________

14. Financial Eligibility:

____ Title XX: ____ SSI ____ OA ____ DA ____ non SSI
____ Sliding Fee
____ Other (specify): ____________________________

15. Insurance:

____ Medicare: ____ Part A, ____ Part B Medex: ___ 1 ___ 2 ___ 3

____ Medicaid: # ____________________ Other: ______________

II. KEY FACTS - ABUSE/NEGLECT SITUATION

1. What was the date when your agency first became involved with this client as a case of abuse/neglect?

Year ______ Month ______ Day ______

2. Who brought this case to your agency's attention as a case of abuse/neglect?

____ personal observation
____ client (self report)
____ member of client's family
____ hospital or clinic
____ police
____ private physician
____ lawyer/paralegal
____ client's friend or neighbor

____ private agency specify: ____________
____ public agency specify: ____________
____ co-worker, job title: ____________
____ other specify: ____________
____ unknown

other key agencies involved:

3(a) Using the following classification scheme, please indicate the nature of this particular abuse/neglect case, e.g., psychological abuse, passive neglect, etc. (Use more than one category if appropriate)

ABUSE:

_____ physical	- the infliction of physical pain or injury, physical coercion (confinement against one's will) e.g., slapped bruised, sexually molested, cut, burned, physically restrained, etc.
_____ psychological	- the infliction of mental anguish, e.g., called names, treated as a child, frightened, humiliated, intimidated, threatened, isolated, etc.
_____ material	- the illegal or improper exploitation and/or use of funds or other resources

NEGLECT:

_____ active	- refusal or failure to fulfill a caretaking obligation, INCLUDING a conscious and intentional attempt to inflict physical or emotional distress on the elder; e.g., deliberate abandonment or deliberate denial of food or health-related services
_____ passive	- refusal or failure to fulfill a caretaking obligation, EXCLUDING a conscious and intentional attempt to inflict physical or emotional distress on the elder; e.g., abandonment, non-provision of food, or health-related services because of inadequate knowledge, laziness, infirmity or disputing the value of prescribed services

(b) Which of the above abuses/neglects precipitated the reporting of this case? ______________________________

(c) Which of the above abuses/neglects do you consider most harmful to the client? ______________________________

4. For how long, approximately, was the person abused/neglected before being discovered by, reported to, your agency?

5. To what extent is the abused/neglected person dependent on the abuser and/or his/her family for the following at this time?

	Independent	Slightly Dependent	Very Dependent	Unknown
financial resources	___	___	___	___
financial management	___	___	___	___
companionship	___	___	___	___
transportation	___	___	___	___
daily needs (meals, Rx)	___	___	___	___
maintenance of property	___	___	___	___
other (specify):				
___________________	___	___	___	___

6. To what extent is the abused/neglected client a source of stress to the perpetrator or his/her family?

a lot ___ a little ___ not at all ___ unknown ___

Specify type of stress:

___ Soiling
___ Verbal (e.g., whining)
___ Demands for attention
___ Wandering
___ Unrealistic expectations
___ Incontinence
___ Others, specify: ________________
____

7. Specify any ways in which you consider the abused/neglected client to have come from an unstable or non-traditional background?

___ non parental upbringing
___ violence or abuse in the home
___ social isolation
___ physical isolation
___ other, specify __________
____
____

8. Relation of perpetrator to abused/neglected client:

___ husband
___ wife
___ son
___ daughter
___ sister
___ brother
___ sister-in-law
___ brother-in-law
___ son-in-law
___ daughter-in-law
___ other relative (specify):

____

___ non-relative (specify):

____

___ unknown

9. Does the perpetrator live with the abused/neglected client:

____ Yes ____ No ____ Unknown

If yes, how long have they lived together? ______________________

10. Have the abused/neglected client and perpetrator had long periods of separation and/or non communication?

____ Yes ____ No ____ Unknown

Please explain:

11. How would you rate the quality of the relationship between the abused/neglected client and his/her perpetrator at this time?

____ poor ____ good ____ excellent

Please elaborate on your response:

12. Describe the major elements of the history of the interaction between abused/neglected and perpetrator (self and family) which may have contributed to the abuse/neglect situation.

13. Were there changes in the situation of the abused or abuser which may have precipitated or exacerbated the abuse/neglect situation?

	Abused	Abuser
Physical health	___	___
Mental Health	___	___
Loss of supports/contacts	___	___
Family relationships	___	___
Financial or job status	___	___
Living arrangements	___	___
Increased dependency	___	___
Provocative behavior	___	___
Other, specify (e.g., client's soiling linen, institutional placement): ______________________ ______________________________	___	___

14. Perpetrator's stated reason for abuse/neglect:

15. Case-worker's assessment of reason for perpetrator's abusing/neglecting:

III. MANIFESTATIONS OF THE ABUSE/NEGLECT

1. Severity of physical abuse sustained (check all that apply):

		Degree of severity		
		mild	moderate	severe
____	none apparent			
____	bruises, welts	____	____	____
____	sprains, dislocations	____	____	____
____	malnutrition	____	____	____
____	burns, scalding	____	____	____
____	abrasions, lacerations	____	____	____
____	wounds, cuts, punctures	____	____	____
____	internal injuries	____	____	____
____	dismemberment	____	____	____
____	sexually molested	____	____	____
____	oversedation	____	____	____
____	hypothermia (subnormal body temp)	____	____	____
____	bone fractures	____	____	____
____	skull fractures	____	____	____
____	direct beatings	____	____	____
____	forced into nursing home	____	____	____
____	tied to bed	____	____	____
____	tied to chair	____	____	____
____	other physical confinement against will (specify): ____________________ ____________________________	____	____	____
____	other (describe): ____________________ ____________________________	____	____	____
____	unknown			

2. Severity of psychological abuse sustained (check all that apply):

____	verbal assault	____	____	____
____	threat	____	____	____
____	intimidation	____	____	____
____	humiliation	____	____	____
____	isolation	____	____	____
____	other (specify): ____________________ ____________________________	____	____	____
____	unknown			

3. Severity of material abuse sustained

		Degree of severity		
		mild	moderate	severe
___	taking possession of money or property of abused/neglected	___	___	___
___	misuse of money or property of abused/ neglected	___	___	___
___	other (specify): ______________________	___	___	___
	______________________________			
___	unknown			

4. Severity of neglect sustained (check all that apply). Consider only neglect related to the non-professional caretaker's failure to fulfill obligations.

		Degree of severity		
		mild	moderate	severe
___	abandoned	___	___	___
___	lack of help house cleaning	___	___	___
___	lack of food	___	___	___
___	lack of heat	___	___	___
___	lack of personal care (e.g., bathing, toileting)	___	___	___
___	lack of supervision generally	___	___	___
___	lack of support/companionship	___	___	___
___	failure to purchase prescribed medications	___	___	___
___	no false teeth when needed	___	___	___
___	no hearing aid when needed	___	___	___
___	no glasses when needed	___	___	___
___	failure to provide other prescribed medical services (specify):	___	___	___
	______________________________			
___	failure to fulfill other caretaking obligations (specify):	___	___	___
	______________________________			
___	unknown			

5. What is the level of threat to the physical/mental health of the abused/neglected as a consequence of the behavior of the perpetrator:

____ life threatening
____ very threatening
____ moderately threatening
____ not really threatening at all
____ unknown

IV. INFORMATION ON CLIENT (ABUSED/NEGLECTED PERSON)

1. Client's age at time of initial reporting:

____ under 60
____ 60-64
____ 65-69
____ 70-74
____ 75-79
____ 80-84
____ 85 and over
____ unknown

2. Race:

____ Native American
____ Black
____ Latino/Latina
____ Asian
____ White
____ Other (specify): ____________________
____ Unknown

3. Religion:

____ Catholic
____ Protestant
____ Jewish
____ None
____ Unknown
____ Other (specify): ____________________

4. Sex:

____ Male
____ Female
____ Unknown

5. What is the approximate annual income of the client?

____ $4,999 or less
____ $5,000 - 9,999
____ $10,000 - $14,999
____ $15,000 - 19,999
____ $20,000 and over
____ Unknown

6. If client lives with others what is the approximate annual income of the household?

____ $4,999 or less
____ $5,000 - $9,999
____ $10,000 - $14,999
____ $15,000 - 19,999
____ $20,000 and over
____ Unknown

Section A: Physical Health

Requires Case Manager's Attention: Narrative:

1. Major Impairments
a. ____________________ ____ Yes ____ No
b. ____________________ ____ ____
c. ____________________ ____ ____
d. ____________________ ____ ____
e. ____________________ ____ ____

2. Date of last doctor's visit: ____________________

3. Please note whether the client requires supportive devices for mobility (specify):

____

4. Medications:

Name	Purpose	Doctor

5. Name(s) of Pharmacy: ____________________________________

6. Does the client appear to manage medications well? ____ Yes ____ No

Section B: Nutrition

1. Is the client on a diet prescribed by a physician or other special diet? ____ Yes ____ No

2. Has the client's weight changed significantly compared to his/her usual adult weight? ____ Yes: ____ Less ____ More ____ No

3. Does the client appear to be eating well? ____ Yes ____ No

Narrative:

Section C: Activities of Daily Living

Please Check problems with which the client has difficulty fulfilling on his/her own:

____ 1. Personal Care (specify areas): Narrative:

a. ______________________________

b. ______________________________

c. ______________________________

____ 2. Mobility/Communications:

a. ______________________________

b. ______________________________

c. ______________________________

____ 3. Mealtime Activities:

a. ______________________________

b. ______________________________

c. ______________________________

____ 4. Safety/Security of Personal Property: Narrative:

a. ______________________________
b. ______________________________
c. ______________________________

____ 5. Management of Financial/Personal Affairs:

a. ______________________________

b. ______________________________

c. ______________________________

____ 6. General Shopping:

a. ______________________________

b. ______________________________

c. ______________________________

____ 7. Transportation:

a. ______________________________

b. ______________________________

c. ______________________________

____ 8. Household Management:

a. ______________________________

b. ______________________________

c. ______________________________

9. Size of Apartment/House:

______ Rooms ______ Floors

Section D: Mental Health

Please note problems which the client has in the following areas and describe in the Narrative section:

1. Behavior and Appearance　　　　Narrative:

   a. ______________________

   b. ______________________

   c. ______________________

2. Attention/Concentration

   a. ______________________

   b. ______________________

   c. ______________________

3. Mood/Emotional Reactions

   a. ______________________

   b. ______________________

   c. ______________________

4. Orientation

   a. Person

   ____ Yes　　　　____ No
   ____ Sometimes　　____ Unknown

   b. Place

   ____ Yes　　　　____ No
   ____ Sometimes　　____ Unknown

   c. Times

   ____ Yes　　　　____ No
   ____ Sometimes　　____ Unknown

5. Memory

a. Immediate

____ Yes ____ No
____ Sometimes ____ Unknown

b. Recent

____ Yes ____ No
____ Sometimes ____ Unknown

c. Remote

____ Yes ____ No
____ Sometimes ____ Unknown

6. Please rate abused/neglected person's emotional state at this time:

____ Excellent
____ Good
____ Poor
____ Unknown

Reason for this rating:

7. Is the client able to give consent?

____ Yes ____ No ____ Unknown

8. Has the abused/neglected ever been a patient in

____ a mental institution
____ a hospital, for a psychiatric diagnosis
____ a developmental center (i.e., retardation)
____ other: specify ____
____ unknown

9. Please rate the self esteem of the abused/neglected.

____ very low
____ moderately low
____ moderately high
____ very high
____ unknown

Section E: Social Contacts (include the perpetrator)

1. Indicate the relationship of persons (include groups) with whom the abused/neglected client has social contact, the type of contact (visit, telephone, letters)...purpose of contact (companionship, nuisance, assistance - specify type)...and frequency.

	Relationship	Type	Purpose	Frequency
a.				
b.				
c.				
d.				
e.				
f.				

2. Indicate who are the significant others who are not part of the social network and the reasons for non-inclusion

	Relationship	Reason
a.		
b.		
c.		
d.		
e.		

3. Does the abused/neglected have someone to call in a crisis?

____ Yes ____ No ____ Unknown

If yes, indicate who: ____________________

Section F: Support Services

1. Check those services which were being actively utilized by the abused/neglected just prior to your agency's intervention.

____ health services
____ meals on wheels
____ senior centers
____ outreach programs
____ homemaker
____ informal supports, specify: ____________________
____ other, specify: ____________________
____ legal services
____ volunteer (e.g., friendly visitor, senior companion)
____ unknown

V. INFORMATION ON ABUSER/NEGLECTOR (i.e., perpetrator)

1. Age at time of initial reporting:

____ 10-19
____ 20-29
____ 30-39
____ 40-49
____ 50-59
____ 60-69
____ 70-79
____ over 80
____ unknown

2. Race:

____ Native American
____ Black
____ Latino/Latina
____ Asian
____ White
____ Other (specify): ____________________
____ Unknown

3. Religion:

____ Catholic
____ Protestant
____ Jewish
____ None
____ Unknown
____ Other (specify): ____________________

4. Sex:

____ Male
____ Female
____ Unknown

5a. Severity of problems perpetrator is experiencing from any of the following (check all that apply)

		Mild	Moderate	Severe
____	alcohol abuse	____	____	____
____	drug abuse	____	____	____
____	long-term medical complaint	____	____	____
____	recent medical complaint	____	____	____
____	recent loss of spouse or significant other through death (specify who): ____________	____	____	____
____	recent loss of spouse or significant other through divorce or separation (specify who): ____________	____	____	____
____	recent birth of child	____	____	____
____	past suicide attempt	____	____	____
____	long-term financial problems	____	____	____
____	recent financial problems other than loss of job	____	____	____
____	history of mental/emotional illness	____	____	____
____	lack of needed services (self or family)	____	____	____
____	other:	____	____	____

5b. Additional comments:

6. Has the perpetrator ever been responsible for additional acts of abuse/neglect to others (check all that apply)?

____ child abuse
____ spouse abuse
____ documented assault and/or battery on others
____ other (specify): ____________
____ unknown

7a. Was the perpetrator abused or neglected as a child?

____ Yes ____ No ____ Unknown

7b. If yes, by whom? ____________

7c. If yes, how? ____________

8. Specify any ways in which you consider the perpetrator to have come from an unstable or untraditional background (e.g., non-parental upbringing, violence or abuse in the home, etc.)

9. To what extent is the perpetrator dependent on the abused/neglected person at this time?

	Independent	Slightly Dependent	Very Dependent	Unknown
Finances	___	___	___	___
Other (specify):	___	___	___	___

____

Please elaborate:

10. Does the perpetrator have unrealistic expectations of the abused/neglected?

___ Yes ___ No ___ Unknown

If yes, please elaborate

11. Does the perpetrator have any family members available for support or assistance?

___ Yes ___ No ___ Unknown

If yes, indicate relationship and type of support:

12. Does the perpetrator have someone to call in a crisis?

___ Yes ___ No ___ Unknown

If yes, indicate who: ______________________________

VI. ACTION TAKEN

1. What initial action has your agency taken in this case? (Include the use of any informal supports; referrals below and legal action below).

2. Referral to (check all that apply):

___ medical facility (specify): ______________________________

____

___ mental health agency (specify): ______________________________

____

___ social service agency (specify): ______________________________

____

___ volunteer group (specify): ______________________________

____

___ police

___ other (specify): ______________________________

____

___ unknown

3. Legal action:

a. Do you think any legal action is appropriate in this case?

____ Yes ____ Not at all ____ Not sure at this time

If yes, please check any of the following actions that might be appropriate:

____ order of protection
____ conservatorship
____ involuntary commitment (psychiatric)
____ short term involuntary protective removal
____ competency
____ representative or protective payee
____ criminal action
____ family court
____ other, specify: ____________________________

b. Have you initiated, or planned to initiate, any of the above legal interventions in this case?

____ Yes ____ No

If yes, indicate from the above list the type of intervention:

c. In you opinion would a mandated reporting law have helped effect earlier or more effective case intervention?

____ Yes ____ No ____ Unknown

d. In your opinion, would a short term, involuntary protective removal law have made earlier or more effective intervention a possibility?

____ Yes ____ No ____ Unknown

4. Rate the degree to which certain potential barriers have hindered, or are likely to hinder, the delivery of appropriate services in this case.

	not hindered	hindered a little	hindered a lot	not applicable
The number of agencies involved	___	___	___	___
Coordination of services involved	___	___	___	___
Coordination of agencies involved	___	___	___	___
Receptivity of abused/neglected to help	___	___	___	___
Receptivity of perpetrator to help	___	___	___	___
Availability of appropriate services	___	___	___	___
Legal implications of intervention	___	___	___	___
Lack of respite care facilities/ shelters	___	___	___	___
Lack of support group for caretakers	___	___	___	___
Lack of protective services	___	___	___	___
Non-reimbursement of services provided	___	___	___	___
Bureaucratic red-tape	___	___	___	___
Other (specify):	___	___	___	___

____

5. Please comment on the way any barriers have been, or will be, overcome in an effort to provide necessary services in this case.

EXHIBIT 2

Agency Name:

Case #/Name Code: ____________________

Case Manager: ____________

Dates during which data were collected: ____________

____

CASE ASSESSMENT
(COMPARISON)

I. KEY FACTS - CLIENTS

1. Name: ____________ 2. Telephone: ____________

3. Address: ____________ 4. Soc. Sec. #: ____________

City/Town: ____________ Zip Code: ____________

5. Primary M.D.: ____________ Telephone: ____________

6. Other M.D.s: ____________ Telephone: ____________

____________ ____________

7. Hospital/Clinic: ____________ Telephone: ____________

8. VNA Nurse: ____________ Telephone: ____________

9. Emergency Contacts:

	Full Name	Address	Tel.	Relationship to Client
a.				
b.				

10. Date of Birth: ____________

11. Marital Status:
____ Single ____ Married ____ Widowed ____ Divorced/Separated

______ Years in this status

12. Household Composition: ____ Lives Alone ____ Lives with Other(s),

State Relationship(s): ________________________

Specify household owner and years client lives in present dwelling:

____

13. If client does not speak or understand English, please note primary language: ______________________

14. Financial Eligibility:

____ Title XX: ____ SSI ____ OA ____ DA ____ non SSI
____ Sliding Fee
____ Other (specify): ______________________

15. Insurance:

____ Medicare: ____ Part A, ____ Part B Medex: ____ 1 ____ 2 ____ 3

____ Medicaid: # ______________________ Other: ______________

II. KEY FACTS

1. What was the date when your agency first became involved with this client?

Year ______ Month ______ Day ______

2. Who brought this case to your agency's attention?

____ personal observation
____ client (self report)
____ member of client's family
____ hospital or clinic
____ police
____ private physician
____ lawyer/paralegal
____ client's friend or neighbor

____ private agency
specify: ______________
____ public agency
specify: ______________
____ co-worker, job
title: ______________
____ other
specify: ______________
____ unknown

other key agencies involved:

3. Is the client dependent on a caretaker and/or his/her family? (For this purpose a caretaker is an individual on whom the client relies for one or more services without which he/she would have great difficulty in continuing to function. The caretaker may or may not be related to the client and may not necessarily live with the client.

Yes____________ No____________

If yes, to what extent is the client dependent on the caretaker for the following at this time?

To what extent is the abused/neglected person dependent on the abuser and/or his/her family for the following at this time?

	Independent	Slightly Dependent	Very Dependent	Unknown
financial resources	____	____	____	____
financial management	____	____	____	____
companionship	____	____	____	____
transportation	____	____	____	____
daily needs (meals, Rx)	____	____	____	____
maintenance of property	____	____	____	____
other (specify):				
______________________	____	____	____	____

4. To what extent is the client a source of stress to the caretaker or his/her family?

a lot ____ a little ____ not at all ____ unknown ____

Specify type of stress:

____ Soiling
____ Verbal (e.g., whining)
____ Demands for attention
____ Wandering
____ Unrealistic expectations
____ Incontinence
____ Others, specify: ________________
____

5. Relation of caretaker to client:

____ husband
____ wife
____ son
____ daughter
____ sister
____ brother
____ sister-in-law
____ brother-in-law
____ son-in-law
____ daughter-in-law
____ other relative (specify):
____
____ non-relative (specify):
____
____ unknown

6. Does the Caretaker live with the client?

____ Yes ____ No ____ Unknown

If yes, how long have they lived together? ____________________

7. Have the client and caretaker had long periods of separation and/or non communication?

____ Yes ____ No ____ Unknown

Please explain:

8 How would you rate the quality of the relationship between the client and his/her caretaker at this time?

____ poor ____ good ____ excellent

Please elaborate on your response:

9. Have there been any recent changes in the situation of the caretaker or client which may have caused unusual stress?

	Abused	Abuser
Physical health	____	____
Mental Health	____	____
Loss of supports/contacts	____	____
Family relationships	____	____
Financial or job status	____	____
Living arrangements	____	____
Increased dependency	____	____
Provocative behavior	____	____
Other, specify (e.g., client's soiling linen, institutional placement): ____________________	____	____

____

III. INFORMATION ON CLIENT

1. Client's age at time of initial reporting:

____ under 60
____ 60-64
____ 65-69
____ 70-74
____ 75-79
____ 80-84
____ 85 and over
____ unknown

2. Race:

____ Native American
____ Black
____ Latino/Latina
____ Asian
____ White
____ Other (specify): ____________________
____ Unknown

3. Religion:

____ Catholic
____ Protestant
____ Jewish
____ None
____ Unknown
____ Other (specify): ____________________

4. Sex:

____ Male
____ Female
____ Unknown

5. What is the approximate annual income of the client?

____ $4,999 or less
____ $5,000 - 9,999
____ $10,000 - $14,999
____ $15,000 - 19,999
____ $20,000 and over
____ Unknown

6. If client lives with others what is the approximate annual income of the household?

____ $4,999 or less
____ $5,000 - $9,999
____ $10,000 - $14,999
____ $15,000 - 19,999
____ $20,000 and over
____ Unknown

Section A: Physical Health

		Requires Case Manager's Attention:		Narrative:
1.	Impairments			
a.	____________	____ Yes	____ No	
b.	____________	____	____	
c.	____________	____	____	
d.	____________	____	____	
e.	____________	____	____	

2. Date of last doctor's visit: ____________

3. Please note whether the client requires supportive devices for mobility (specify):

____

4. Medications:

Name	Purpose	Doctor
____	____	____
____	____	____
____	____	____
____	____	____

5. Name(s) of Pharmacy: ____

6. Does the client appear to manage medications well? ____ Yes ____ No

Section B: Nutrition

1. Is the client on a diet prescribed by a physician or other special diet? ____ Yes ____ No
2. Has the client's weight changed significantly compared to his/her usual adult weight? ____ Yes: ____ Less ____ More ____ No
3. Does the client appear to be eating well? ____ Yes ____ No

Narrative:

Section C: Activities of Daily Living

Please Check problems with which the client has difficulty fulfilling on his/her own:

____ 1. Personal Care (specify areas): Narrative:

a. ____________________

b. ____________________

c. ____________________

____ 2. Mobility/Communications:

a. ____________________

b. ____________________

c. ____________________

____ 3. Mealtime Activities:

a. ____________________

b. ____________________

c. ____________________

____ 4. Safety/Security of Personal Property: Narrative:

a. ____________________
b. ____________________
c. ____________________

____ 5. Management of Financial/Personal Affairs:

a. ____________________

b. ____________________

c. ____________________

____ 6. General Shopping:

a. ______________________________

b. ______________________________

c. ______________________________

____ 7. Transportation:

a. ______________________________

b. ______________________________

c. ______________________________

____ 8. Household Management:

a. ______________________________

b. ______________________________

c. ______________________________

9. Size of Apartment/House:

______ Rooms ______ Floors

Section D: Mental Health

Please note problems which the client has in the following areas and describe in the Narrative section:

1. Behavior and Appearance

Narrative:

a. ______________________________

b. ______________________________

c. ______________________________

2. Attention/Concentration

a. ________________________

b. ________________________

c. ________________________

3. Mood/Emotional Reactions

a. ________________________

b. ________________________

c. ________________________

4. Orientation

a. Person

____ Yes
____ Sometimes
____ No
____ Unknown

b. Place

____ Yes
____ Sometimes
____ No
____ Unknown

c. Times

____ Yes
____ Sometimes
____ No
____ Unknown

5. Memory

a. Immediate

____ Yes
____ Sometimes
____ No
____ Unknown

b. Recent

____ Yes
____ Sometimes
____ No
____ Unknown

c. Remote

____ Yes
____ Sometimes
____ No
____ Unknown

6. Please rate client's emotional state at this time:

____ Excellent
____ Good
____ Poor
____ Unknown

Reason for this rating:

7. Is the client able to give consent?

____ Yes ____ No ____ Unknown

8. Has the client ever been a patient in

____ a mental institution
____ a hospital, for a psychiatric diagnosis
____ a developmental center (i.e., retardation)
____ other: specify ________________________________
____ unknown

9. Please rate the self esteem of the client.

____ very low
____ moderately low
____ moderately high
____ very high
____ unknown

Section E: Social Contacts (include the caretaker)

1. Indicate the relationship of persons (include groups) with whom the client has social contact, the type of contact (visit, telephone, letters)...purpose of contact (companionship, nuisance, assistance - specify type)...and frequency.

	Relationship	Type	Purpose	Frequency
a.				
b.				
c.				
d.				
e.				
f.				

2. Indicate who are the significant others who are not part of the social network and the reasons for non-inclusion

Relationship	Reason
a. ________	________
b. ________	________
c. ________	________
d. ________	________
e. ________	________

3. Does the client have someone to call in a crisis?

____ Yes ____ No ____ Unknown

If yes, indicate who: ____________________

Section F: Support Services

1. Check those services which were being actively utilized by the client just prior to your agency's involvement.

____ health services
____ meals on wheels
____ senior centers
____ outreach programs
____ homemaker
____ informal supports, specify: ____________________
____ other, specify: ____________________

____ legal services
____ volunteer (e.g., friendly visitor, senior companion)
____ unknown

V. INFORMATION ON PRINCIPAL CARETAKER (if any)

1. Age at time of initial reporting:

____ 10-19
____ 20-29
____ 30-39
____ 40-49
____ 50-59
____ 60-69
____ 70-79
____ over 80
____ unknown

2. Race:

____ Native American
____ Black
____ Latino/Latina
____ Asian
____ White
____ Other (specify): ____________________
____ Unknown

3. Religion:

____ Catholic
____ Protestant
____ Jewish
____ None
____ Unknown
____ Other (specify): ____________________

4. Sex:

____ Male
____ Female
____ Unknown

5a. Severity of problems caretaker is experiencing from any of the following (check all that apply)

		Mild	Moderate	Severe
___	alcohol abuse	___	___	___
___	drug abuse	___	___	___
___	long-term medical complaint	___	___	___
___	recent medical complaint	___	___	___
___	recent loss of spouse or significant other through death (specify who): ________ ________	___	___	___
___	recent loss of spouse or significant other through divorce or separation (specify who): ________	___	___	___
___	recent birth of child	___	___	___
___	past suicide attempt	___	___	___
___	long-term financial problems	___	___	___
___	recent financial problems other than loss of job	___	___	___
___	history of mental/emotional illness	___	___	___
___	lack of needed services (self or family)	___	___	___
___	other:	___	___	___

5b. Additional comments:

6. To what extent is the caretaker dependent on the client at this time?

	Independent	Slightly Dependent	Very Dependent	Unknown
Finances	___	___	___	___
Other (specify): ________	___	___	___	___

Please elaborate:

7. Does the caretaker have unrealistic expectations of the client?

_____yes _____no _____Unknown

8. Does the caretaker have any family members available for support or assistance?

_____yes _____no _____Unknown

9. Does the caretaker have someone to call in a crisis?

_____yes _____no _____Unknown

If yes, indicate who: ________________________________

VI. ACTION TAKEN

1. What initial action has your agency taken in this case? (Include the use of any informal supports; referrals below and legal action below).

2. Referral to (check all that apply):

____ medical facility (specify): ______________________________

____

____ mental health agency (specify): ___________________________

____

____ social service agency (specify): __________________________

____

____ volunteer group (specify): ______________________________

____

____ police

____ other (specify): ___________________________________

____

____ unknown

3. Rate the degree to which certain potential barriers have hindered, or are likely to hinder, the delivery of appropriate services in this case.

	not hindered	hindered a little	hindered a lot	not applicable
The number of agencies involved	___	___	___	___
Coordination of services involved	___	___	___	___
Coordination of agencies involved	___	___	___	___
Receptivity of client to help	___	___	___	___
Receptivity of caretaker to help	___	___	___	___
Availability of appropriate services	___	___	___	___
Legal implications of intervention	___	___	___	___
Lack of respite care facilities/ shelters	___	___	___	___
Lack of support group for caretakers	___	___	___	___
Lack of protective services	___	___	___	___
Non-reimbursement of services provided	___	___	___	___
Bureaucratic red-tape	___	___	___	___
Other (specify): ______________________________	___	___	___	___

4 Please comment on the way any barriers have been, or will be, overcome in an effort to provide necessary services in this case.

5. What do you see as the greatest threats to the client's continued well-being and independence?

6. In what areas do you consider the client to be most vulnerable?

Agency Name:
40

EXHIBIT 3

Case #/Name Code: ____________________; Date(s) of reassessment: _________

OUTCOME REASSESSMENT

Please specify changes in each of the following areas using the last assessment for reference.

II. ABUSE/NEGLECT SITUATION

1. Indicate any changes in the way the abused/neglected person is dependent on the perpetrator and/or his/her family, since the last assessment (QII:5, p.4 in the original assessment).

Dependency type	Independent	Slightly Dependent	Very Dependent
1.	____	____	____
2.	____	____	____
3.	____	____	____
4.			

Elaborate on changes that have occurred:

2. Indicate any changes since the last assessment by rating the status of the abused/neglected presently as a source of stress (QII:6, p.4 in the original assessment).

a lot stressful _____ a little stressful _____ not at all stressful _____ unknown _____

Elaborate on changes in the way the client is a source of stress:

3. Comment on any changes, and their effects, in circumstances in the life of the abused/neglected which were reported previously to have precipitated or exacerbated the abuse/neglect situation (QIII:13, p. 6 on the original assessment).

4. Comment on any changes, and their effects, in circumstances in the life of the perpetrator which were reported previously to have precipitated or exacerbated the abuse/neglect situation (QIII:13, p. 6 in the original assessment).

5. How would you rate the quality of the relationship between the abused/neglected client and his/her perpetrator at this time? (QII:11, p. 5 in the original assessment).

Poor ____ Good ____ Excellent ____

Please elaborate on reasons for any changes since the last assessment.

III. MANIFESTATIONS OF ABUSE/NEGLECT

6. Indicate changes in the severity of new and old manifestations of abuse/neglect since the last assessment (QIII:1,2,3,4, pp. 7-8 in initial assessment)

Previously reported symptoms	Severity Index			
	Mild	Moderate	Severe	No longer a problem
1.	____	____	____	____
2.	____	____	____	____
3.	____	____	____	____
4.	____	____	____	____
5.	____	____	____	____
6.	____	____	____	____
7.	____	____	____	____
8.	____	____	____	____

New symptoms	Severity Index		
	Mild	Moderate	Severe
1.	____	____	____
2.	____	____	____
3.	____	____	____
4.	____	____	____

7. Indicate any changes since the last assessment by rating the level of threat posed by the perpetrator to the physical/mental health of the abused/neglected (QIII:5, p. 9 in the original assessment).

____ life threatening
____ very threatening
____ moderately threatening
____ not really threatening at all
____ unknown

IV. INFORMATION ON CLIENT

Section D: Mental Health

8. Please indicate changes in the client's mental health since the last assessment (Q IVD, p. 13 in initial assessment).

(a) behavior and appearance

(b) attention and concentration

(c) mood/emotional reactions

(d) orientation:

i. person

____ yes
____ sometimes
____ no
____ unknown

ii. place

____ yes
____ sometimes
____ no
____ unknown

iii. time

____ yes
____ sometimes
____ no
____ unknown

(e) memory:

immediate

____ yes
____ sometimes
____ no
____ unknown

recent

____ yes
____ sometimes
____ no
____ unknown

remote

____ yes
____ sometimes
____ no
____ unknown

(f) Rate the abused/neglected person's emotional state at this time:

Give reasons for any change in status since last time:

____ excellent
____ good
____ poor
____ unknown

(g) Please rate the self esteem of the abused/neglected presently:

____ very low
____ moderately low
____ moderately high
____ very high
____ unknown

Section E: Social Contacts

9. Indicate any significant changes in the social contact system of abused/neglected since the last assessment, with respect to additions, deletions, modifications, indicating relationship (include clubs and people), type of contact (e.g., visit, telephone, letter), purpose (e.g., companionship, nuisance, assistance and type of assistance) and frequency. Comment particularly on changes in contacts between abused/neglected and perpetrator (QIV E, p. 15 in initial assessment).

V. INFORMATION ON ABUSER/NEGLECTOR

10. Indicate changes in the severity of new and old problems experienced by the perpetrator since the last assessment (QV:5a, p. 17 in the original assessment).

Previously Reported Problems	Severity Index mild	moderate	severe	no longer a problem
1.	___	___	___	___
2.	___	___	___	___
3.	___	___	___	___
4.	___	___	___	___
5.	___	___	___	___

New Problems	mild	moderate	severe
1.	___	___	___
2.	___	___	___
3.	___	___	___

Please comment on the above changes:

11. Indicate any changes in the way the perpetrator is dependent on the abused/neglected person since the last assessment (QV:9, p.18 in the original assessment).

Dependency	Independent	Slightly Dependent	Very Dependent
1.	___	___	___
2.	___	___	___

Elaborate on changes that have occurred:

VI. ACTION TAKEN

12a. What changes have been made in service delivery/case management for this case of abuse/neglect since the last assessment, including referrals and legal action (QVI: 1,2,3, p. 19-20 in the original assessment).

b. Why were the above changes in service delivery/case management initiated?

13. Indicate changes in the status of barriers to effective case management since the last assessment (QVI:4, p. 21 in initial assessment).

Previously reported barriers	not hindered	hindered a little	hindered a lot	no longer a barrier
1.	___	___	___	___
2.	___	___	___	___
3.	___	___	___	___
4.	___	___	___	___
5.	___	___	___	___

New barriers

1.	___	___	___
2.	___	___	___
3.	___	___	___
4.	___	___	___

Comment, also, in narrative, on ways barriers have either been overcome or arisen since the last assessment (QVI:5, p. 21 in initial assessment).

14a. To what extent have the abuse/neglect aspects of this case been resolved at this point:

Not at all ____ A little ____ A lot ____ Completely ____

Please elaborate:

b. Indicate which factors relating to case management, the abused/neglected and perpetrator, and the abuse/neglect situation, have had significant impact on this resolution status.

50 FINAL ASSESSMENT

Indicate the degree to which the following made a positive or negative contribution to the effective resolution of this abuse/neglect case.

Type of intervention	Somewhat positive	Very positive	No Effect	Very negative	Somewhat negative	Not Applicab
a. changes in social or living situation of abused/neglected	___	___	___	___	___	___
b. removal of barriers to intervention	___	___	___	___	___	___
c. specific intervention strategies	___	___	___	___	___	___
d. changes in unhealthy interdependencies between perpetrator and abused/neglected	___	___	___	___	___	___
e. reduction in stress caused by abused/neglected	___	___	___	___	___	___
f. reduction in problems in life of perpetrator	___	___	___	___	___	___
g. changes in circumstances of perpetrator which precipitated abuse/neglect	___	___	___	___	___	___
h. changes in circumstances of abused/neglected which precipitated abuse/neglect	___	___	___	___	___	___
i. other, specify: ________ ________________________	___	___	___	___	___	___

Please elaborate on factors making a positive contribution:

EXHIBIT 4

INTERVIEW WITH ELDERLY RESPONDENT

COVER SHEET

1. Subject Number______________________________

2. Date of Interview____________________________

3. Time Interview Began_________________________

4. Place of Interview___________________________

5. Model Project Contact Person_________________

Standard Codes for all items: Unknown = 9, 99, 999

Refused or non-responsive answer = 8, 88, 888

Not applicable = 7, 77, 777

INFORMED CONSENT

We are currently conducting interviews with people over the age of 60. The purpose of our study is to find out about the lives of older people; what problems they have, for example, and what services they might need. We are expecially interested in how older people get along with their families. The family often is very helpful to older members, but can also cause some strains. We hope to find out what family life is like for the elderly.

I want to assure you that your answers will be held strictly confidential. Your name will not appear anywhere on the questionnaire, so your answers cannot be connected with you in any way. You are one of 120 people who will be interviewed, and your answers will never be identified separately. I also want to make sure you understand that you may choose not to answer any question, and that you may end the interview at any time.

I CERTIFY THAT I HAVE READ THE ABOVE STATEMENT TO THE RESPONDENT AND THAT HE/SHE HAS UNDERSTOOD THIS STATEMENT AND HAS GIVEN PERMISSION TO CONDUCT THE INTERVIEW.

______________________________ (INTERVIEWER)

______________________________ (DATE)

DEMOGRAPHIC

I am going to start the interview with some general background questions about you and the people you live with.

1. Sex of Subject (interviewer note)

Male..................1

Female................2

2. Race of Subject (interviewer note)

White (Caucasian)......1

Black..................2

Oriental...............3

Hispanic...............4

Other..................5

3. When were you born?

____ ____ ____
month day year

4. How far did you go in school?

0-6 years............. 01 77

7-9 years..............02 88

some high school.......03 99

high school graduate...04

some college or
vocational training....05

college graduate.......06

post graduate study....07

5. What is your marital status?

Single (never married)......1 7
Married....................2 8
Widowed....................3 9
Divorced...................4
Separated..................5

a. How many years in this status? ____________

6. About how many years have you lived at this address? ____________

7. Do you own your own home, pay rent, or what?

Own...............1 7
Rent..............2 8
Other.............3 9

Specify ______________________________

8. What countries or part of the world did your parents or grandparents come from?

____

9. What is your religious preference?

Catholic..........1 7
Protestant........2 8
Denomination ________ 9
Jewish 3
Other.............4

Specify ______________________________

PSC

55

10. Are you presently working full-time, part-time, retired, keeping house, or what?

Working full time.....1 7

Working part-time.....2 8

Retired...............3 9

Keeping house.........4

Unemployed 5

Other.................6

11. If working: what kind of work do you do? ______________________

a. What kind of work have you done most of your life?

____

12. Now, I'd like to find out who lives here with you. Could you tell me who lives here?

a. For each ask:

1. How are they related to you?

2. How old are they?

3. What is their marital status?

4. How many years in this status?

RELATIONSHIP (OR CONNECTION) TO RESPONDENT	SEX	AGE	MARITAL STATUS	LENGTH OF TIME
RESPONDENT				

USE THESE CODES TO SHOW MARITAL STATUS OF EACH RESIDENT:
M=Married, S=Single, D=Divorced, W=Widowed, SP=Separated ______________

b. Total number in household ______________

13. How many rooms are there in your house/apartment? ______________

HEALTH AND FUNCTIONAL STATUS

Now, I'd like to ask you some questions about your health and your ability to get around.

14. How would you rate your overall health at the present time?

Excellent.........1   7

Good..............2   8

Fair..............3   9

Poor..............4

15. I'm going to read you a list of health problems that older people sometimes experience. Do you have any of the following conditions? If YES, ASK: How much does it interfere with your activities: not at all, a little, or a great deal?

	No	If Yes, does it interfere		
		Not at all	Little	Great deal
		3	2	1
a. Arthritis or rheumatism				
b. Glaucoma				
c. Emphysema/Chronic Bronchitis				
d. Tuberculosis				
e. High blood pressure				
f. Circulation problems				
g. Diabetes				
h. Ulcers (digestive tract)				
i. Other stomach disorders				
j. Liver disease				
l. Urinary tract/Prostate				
m. Cancer or leukemia				
n. Anemia				
o. Effects of stroke				
p. Parkinson's disease				
q. Epilepsy				
r. Cerebral Palsy				
s. Multiple Sclerosis				
t. Multiple Dystrophy				
u. Thyroid/glandular disease				
v. Skin disorders/sores				
w. Speech Impediment				
x. Mental of Emotional Problems				
y. Other				

16. In the past year, have you been admitted overnight to a hospital?

Yes...............1	7
No................2	8
	9

a. If yes: what type (acute, chronic, mental, etc.)

____

17. If YES to Q. 24: How many times were you aduitted?

____

18. Is your health now better, about the same, or worse than it was five years ago?

Better............1	7
About the same....2	8
Worse.............3	9

Explain: ______________________________

____

____

____

19. Is your health now better, about the same, or worse than it was one year ago?

Better............1	7
About the same....2	8
Worse.............3	9

Explain: ______________________________

____

____

______________ ______________

Now, I would like to ask you a few questions about activities that some people over 60 find they need help with.

20. First, I will ask you about your meals, do you prepare them yourself?

____(1) Yes ____(2) No 7 8 9 Check Box if Response has Problem (P)

21. If YES, ASK: Do you have great difficulty doing it yourself?

If NO, ASK: Do you need this help?

____(1) Yes(P) ____(2) No 7 8 9

22. Who helps you? ____________________

23. If A/C not mentioned: Does A/C help you at all in this?

____(1) Yes ____(2) No 7 8 9

24. What kind of help do you receive? ____________________

25. Do you take out the garbage yourself?

____(1) Yes ____(2) No

26. If YES, ASK: Do you have great difficulty doing it yourself? __________

If NO, ASK: Do you need this help?

____(1) Yes(P) ____(2) No

27. Who helps you? ____________________

28. IF A/C NOT MENTIONED, ASK: Does A/C help you at all in this? __________

29. What kind of help do you receive? ______________________________

30. Are you healthy enough to do the ordinary work around the house without help?

____(1) Yes ____(2) No(P)

31. IF NO, ASK: Who helps you? ______________________________

32. IF A/C NOT MENTIONED, ASK: Does A/C help you at all in this?

____(1) Yes ____(2) No

33. What kind of help do you receive? ______________________________

34. Are you healthy enough to walk up and down stairs without help?

____(1) Yes ____(2) No(P)

35. If NO, ASK: Who helps you? ______________________________

a. What kind of help do you receive? ______________________________

36. IF A/C NOT MENTIONED, ASK: Does A/C help you at all in this?

____(1) Yes ____(2) No

a. What kind of help do you receive? ______________________________

37. Do you use a walker or 4-pronged cane at least some of the time, to get around?

____(1) Yes (P) ____(2) No

38. Do you use a wheelchair at least some of the time, to get around?

____(1) Yes (P) ____(2) No

39. Could you please tell me what year it is?

____(1) Correct ____(2) Incorrect (P)

A. RECORD NUMBER OF (P) BOXES CHECKED FOR Q 28-44 ____________________

40. In the last month, how many days a week have you usually gone out of the house or building in which you live?

____(1) Two or more days a week

____(2) One day a week or less (P)

41. Does anyone help you go out?

____(1) Yes ____(2) No

42. IF YES, ASK: Who helps you? ____________________

43. IF A/C NOT MENTIONED, ASK: Does (A/C) help you at all in this?

____(1) Yes ____(2) No

44. What kind of help do you receive? ____________________

45. Are you able to dress yourself (including shoes and socks) without help?

____(1) Yes ____(2) No (P)

46. IF NO, ASK: Who helps you? ____________________

47. IF A/C NOT MENTIONED, ASK: Does (A/C) help you at all in this?

____(1) Yes ____(2) No

48. What kind of help do you receive? ____________________

49. How much of the time does bad health, sickness, or pain stop you from doing things you would like to be doing?

____(1) Seldom, sometimes or never

____(2) Frequently or most of the time (P)

50. Do you need help with feeding (includes cutting food)?

____(1) Feeds self ____(2) Receives Assistance (P)

51. IF RECEIVES ASSISTANCE, ASK: Who helps you? ______________________________

52. If A/C NOT MENTIONED, ASK: Does (A/C) help you at all in this?

____(1) Yes ____(2) No

53. What kind of help do you receive?

B. RECORD NUMBER OF (P) BOXED CHECKED FOR 048-60 ____________________________

54. Do you need help with shopping for food?

Yes.............1 7

No..............2 8

9

55. IF YES, ASK: Who helps you? ____

56. IF (A/C) NOT MENTIONED, ASK: Does (A/C) help you at all in this?

Yes.............1 7

No..............2 8

9

57. What kind of help do you receive? ______________________________

58. Are you required to take any medications?

Yes...............1   7
No................2   8
9

59. IF YES, ASK: Does anyone help you with taking your medications?

Yes...............1   7
No................2   8
9

60. IF YES, ASK: Who helps you? ______________________________

61. IF A/C NOT MENTIONED, ASK: Does (A/C) help you at all in this?

Yes...............1   7
No................2   8
9

62. What kind of help do you receive? ______________________________

63. How many different medications do you take? ______________________

64. Are you required to get any shots or injections regularly?

Yes...............1   7
No................2   8
9

64

65. Are you generally able to take a bath or shower without help?

Yes...............1 7
No................2 8
9

66. IF NO, ASK: Who helps you? ______________________________

67. IF A/C NOT MENTIONED, ASK: Does (A/C) help you at all in this?

Yes...............1 7
No................2 8
9

68. What kind of help do you receive? ______________________________

69. Do you have a telephone here?

Yes...............1 7
No................2 8
9

70. IF YES, ASK: Are you able to use the telephone without help?

Yes...............1 7
No................2 8
9

71. IF NO, ASK: Who helps you? ______________________________

72. IF A/C NOT MENTIONED, ASK: Does (A/C) help you at all in this?

Yes................1 7
No.................2 8
9

73. What kind of help do you receive? ______________________________

74. In all of these areas that I have just mentioned, do you feel that the help you are receiving will continue in the future?

Yes................1 7
No.................2 8
9

a. Why or why not?

75. Are you receiving help in any other areas I have not mentioned?

76. Would you like help (or more help) in any areas? Which ones?

77. POSSIBLE PROBE HERE: IF A/C HAS BEEN FREQUENTLY CITED AS HELPER, ASK: It sounds like (A/C) helps you a lot. Do you depend on him/her to a great deal? Is he/she generally willing to help you? Are there any problems in getting help from him/her?

SOCIAL SUPPORT

78. How many people do you know well enough to visit in their homes?

Five or more......3 7
Three to four.....2 8
One to two........1 9
None..............0

79. About how many times did you talk to someone--friends, relatives, or others--on the telephone in the past week (either you called them or they called you)?

Once a day or more.....3 7
2-6 times..............2 8
Once...................1 9
Not at all.............0

80. How many times in the past week did you spend some time with someone who does not live with you, that is you went out to see them or they came to visit you, or you went out to do things together?

Once a day or more.....3 7
2-6 times..............2 8
Once...................1 9
Not at all.............0

81. Do you have someone you can trust and confide in?

Yes...............2 7
No................0 8
9

82. Do you find yourself feeling lonely quite often. sometimes, or almost never?

Quite often.......0 7

Sometimes.........1 8

Almost never......2 9

83. Do you see your relatives and friends as often as you want to or are you somewhat unhappy about how little you see them?

As often as wants to.................1 7

Somewhat unhappy about how little....2 8

9

84. Is there someone who would give you any help at all if you were sick or disabled, for example, your husband/wife, a member of your family, or a friend?

Yes................................1 7

No one willing and able to help....2 8

9

85. IF YES, ASK: Is there someone who would take care of you as long as needed, or only for a short time, or only someone who would help you now and then (for example, taking you to the doctor, or fixing lunch occasionally, etc)?

Someone who would take care of subject indefinitely (as long as needed).........................1 7

Someone who would take care of subject for a short time (a few weeks to six months)...............2 8

Someone who would help the subject now and then (taking him/her to the doctor, fixing lunch, etc).....3 9

a. Who is this person?

Name ____________________

Relationship ____________________

86. Do you belong to a church, club or other organizations?

Yes...............1 7

No................2 8

9

a. IF YES, ASK: What are they? ____________________

b. How frequently do you attend each of these? ____________________

87. We have just been talking about your relationships with other people. Have these changed substantially in any way in the last five years (for example, do you see people less or more than you used to, or get more or fewer calls)?

Yes...............1 7

No................2 8

9

a. IF YES, ASK: Could you please explain?

88. How about in the last year?

Yes...............1 7

No................2 8

9

70

a. IF YES, ASK: Could you please explain?

89. Has your relationship with anyone you live with had an effect on your contact with others?

Yes...............1 7

No................2 8

9

a. IF YES, ASK: Could you please explain?

90. IF A/C NOT MENTIONED, ASK: Has your relationship with (A/C) had an effect on your contact with others?

Yes...............1 7

No................2 8

9

a. IF YES, ASK: Could you please explain?

We've talked about the family who lives here with you. Now I'd like to ask you about your other relatives (SKIP 100 AND 103 IF NEVER MARRIED)

91. How many sons do you have? ______________________________

92. FOR EACH SON, ASK: Does he live nearby (an hour's drive or less)?

93. FOR EACH SON, ASK: How often do you see him and/or talk on the telephone?

SON (Name)	**LIVES NEARBY** (1=Yes, 2=No)	**FREQUENCY OF CONTACT** (1=Daily, 2=2-6x week, 3=1x week -1x month, 4=less than 1x month)
a. ______________	1 2 7 8 9	1 2 3 4 7 8 9
b. ______________	1 2 7 8 9	1 2 3 4 7 8 9
c. ______________	1 2 7 8 9	1 2 3 4 7 8 9
d. ______________	1 2 7 8 9	1 2 3 4 7 8 9
e. ______________	1 2 7 8 9	1 2 3 4 7 8 9

94. How may daughters do you have? ______________________________

95. FOR EACH DAUGHTER, ASK: Does she live nearby (an hour's distance or less)?

96. FOR EACH DAUGHTER, ASK: How often do you see her?

DAUGHTER (Name)	**LIVES NEARBY** (1=Yes, 2=No)	**FREQUENCY OF CONTACT** (1=Daily, 2=2-6x week, 3=1x week -1x month, 4=less than 1x month)
a. ______________	1 2 7 8 9	1 2 3 4 7 8 9
b. ______________	1 2 7 8 9	1 2 3 4 7 8 9
c. ______________	1 2 7 8 9	1 2 3 4 7 8 9
d. ______________	1 2 7 8 9	1 2 3 4 7 8 9
e. ______________	1 2 7 8 9	1 2 3 4 7 8 9

97. How many brothers do you have? ________________________________

98. FOR EACH BROTHER, ASK: Does he live nearby (an hour's drive or less)?

99. FOR EACH BROTHER, ASK: How often do you see him and/or talk on the telephone?

BROTHER	LIVES NEARBY	FREQUENCY OF CONTACT
(Name)	(1=Yes, 2=No)	(1=Daily, 2=2-6x week, 3=1x week -1x month, 4=less than 1x month)
a. ________________	1 2 7 8 9	1 2 3 4 7 8 9
b. ________________	1 2 7 8 9	1 2 3 4 7 8 9
c. ________________	1 2 7 8 9	1 2 3 4 7 8 9
d. ________________	1 2 7 8 9	1 2 3 4 7 8 9
e. ________________	1 2 7 8 9	1 2 3 4 7 8 9

100. How may sisters do you have? ________________________________

101. FOR EACH SISTER, ASK: Does she live nearby (an hour's distance or less)?

102. FOR EACH SISTER, ASK: How often do you see her?

SISTER	LIVES NEARBY	FREQUENCY OF CONTACT
(Name)	(1=Yes, 2=No)	(1=Daily, 2=2-6x week, 3=1x week -1x month, 4=less than 1x month)
a. ________________	1 2 7 8 9	1 2 3 4 7 8 9
b. ________________	1 2 7 8 9	1 2 3 4 7 8 9
c. ________________	1 2 7 8 9	1 2 3 4 7 8 9
d. ________________	1 2 7 8 9	1 2 3 4 7 8 9
e. ________________	1 2 7 8 9	1 2 3 4 7 8 9

STRESS

Every family experiences stress from time to time. I am now going to ask you some questions about what might cause stress in this household.

103. What do you find stressful in your life right now? (Probe: What do you tend to worry about?)

104. Sometimes financial problems can create stress. Is having enough money a problem for you?

Yes...............1 7

No................2 8 Comment:________________________

9 ________________________

____

105. I am going to read a list of events which may have occurred in the life of someone living in this household. Please indicate those events which have occurred to someone here in the past year, and whom they have happened to.

74

		IN LAST YEAR			
		Yes, Has Happened	Household Member	No, Has not Happened	
a.	Someone in the household died	1	________	2	7 8 9
b.	A close relative of someone in the household died	1	________	2	7 8 9
c.	Someone in the household has been ill or injured	1	________	2	7 8 9
d.	Someone in the household was divorced	1	________	2	7 8 9
e.	Someone in the household was married	1	________	2	7 8 9
f.	Someone in the household was arrested	1	________	2	7 8 9
g.	Someone left the household to move elsewhere	1	________	2	7 8 9
h.	Someone joined the household from somewhere else	1	________	2	7 8 9
i.	Someone in the household lost a job	1	________	2	7 8 9
j.	Someone in the household retired	1	________	2	7 8 9
k.	The household had to change residence	1	________	2	7 8 9

106. FOR EACH ANSWER "YES, HAS HAPPENED,"

PROBE: What was this like for you?

Did this event affect your relationship with (A/C)?

FAMILY HISTORY

Now, I would like to ask you some questions about the family you grew up in.

107. What was your family life like when you were growing up? (PROBE: Would you say you were a happy family? Why or why not?)

108. Did you live with both your natural parents as a child and teenager?

Yes...............1   7

No................2   8

9

a. IF NO, ASK: Were your natural parents divorced, separated, did one or both of them die, or was there some other reason you were not living with them as a child or teenager?

Divorced or Separated......1   7

One died...................2   8

Both died..................3   9

Respondent was adopted.....4

Other......................5

Specify ______________________________

109. Were there any (any other) problems in your childhood or teenage years that you could tell me about?

[IF (A/C) CHILD OF RESPONDENT OR RAISED BY RESPONDENT, ASK Q. 101-105]

110. Now, I would like to ask you about your relationship with your children as they were growing up.

a. What was your relationship with your children like when they were young? (PROBE: With A/C?)

b. Many parents find it necessary to discipline their children when they misbehave. How did you usually punish your children? (PROBE: How about A/C?)

111. Still thinking about when (A/C) was a child and teenager, about how often would you say you used physical punishment, like slapping or hitting him/her? Think about the year in which this happened the most.

Never.................0 7
Once..................1 8
Twice.................2 9
3-5 times.............3
6-10 times............4
11-20 times...........5
More than 20 times....6

112. How about your husband/wife? Again, thinking of the year in which it happened the most, how often would you say he used physical punishment in the course of a year?

Never.................0 7
Once..................1 8
Twice.................2 9
3-5 times.............3
6-10 times............4
11-20 times...........5
More than 20 times....6

a. How about with your other children? Did you discipline them in the same way? Or was A/C different?

INTERPERSONAL RELATIONSHIPS

I would now like to ask you some questions about your living situation.

113. How satisfied are you with your current living situation?

Very satisfied........1

Somewhat satisfied....2

Somewhat unsatisfied..3

Very unsatisfied......4

a. Could you explain your answer?

114. IF LIVES WITH MORE THAN ONE OTHER PERSON, ASK: Whom do you get along best with in your living situation? ______________________________

a. Why do you think this is?

115. IF LIVES WITH MORE THAN ONE OTHER PERSON, ASK: With whom do you get along least well in your living situation? ______________________

b. Why do you think this is?

116. FOR PERSON NOT LIVING WITH SPOUSE: Please tell me how you came to live here? (PROBE: What made you decide to live with (relative).

117. Living with others can offer rewards and satisfactions. What are the things that please you most about your living situation?

118. It also often happens that living together can bring about conflicts and tension. What things please you the least about your living situation?

119. Now, I would like to ask you some questions about (A/C). How would you describe your relationship with him/her?

120. What would you say are the most positive things about your relationship with him/her?

121. What would you say are the biggest difficulties in your relationship with him/her?

122. People often depend on each other for many things. How much do you depend on (A/C) in the following areas:

		115.			116.	
	Entirely Dependent	Somewhat Dependent	Independent		Problem	No Problem
a. Housing	2	1	0	7 8 9	1	0
b. Cooking or cleaning	2	1	0	7 8 9	1	0
c. Household repair	2	1	0	7 8 9	1	0
d. Companionship, social activities	2	1	0	7 8 9	1	0
e. Financial support	2	1	0	7 8 9	1	0
f. Transportation	2	1	0	7 8 9	1	0
g. Other	2	1	0	7 8 9	1	0

123. FOR EACH ITEM ANSWERED "ENTIRELY DEPENDENT" OR "SOMEWHAT DEPENDENT", ASK RESPONDENT, Does this dependency cause any problems for you? IF YES, ASK: Please expain.

124. Now, how much does (A/C) depend on you in these areas?

	117.				118.	
	Entirely Dependent	Somewhat Dependent	Independent		Problem	No Problem
a. Housing	2	1	0	7 8 9	1	0
b. Cooking or cleaning	2	1	0	7 8 9	1	0
c. Household repair	2	1	0	7 8 9	1	0
d. Companionship, social activities	2	1	0	7 8 9	1	0
e. Financial support	2	1	0	7 8 9	1	0
f. Transporation	2	1	0	7 8 9	1	0
g. Other	2	1	0	7 8 9	1	0

125. FOR EACH ITEM ANSWERED "ENTIRELY DEPENDENT" OR "SOMEWHAT DEPENDENT", ASK RESPONDENT, Does this dependency cause any problems for you? IF YES, ASK: Please expain.

IF A/C IS A SPOUSE, ASK Q. 119-120. IF A/C IS OTHER RELATIVE, ASK 0. 121-122.

126. Every couple has their ups and downs, and surveys like this have shown that at some time or other, most people wonder about whether they should continue their marriage. What about in your case? Have you ever thought about this?

Yes...............1 7

No................2 8

9

a. IF YES, ASK: How much have you thought about it? Was it once, a few times, or a lot?

Once	1	7
A few times	2	8
A lot	3	9

b. When you thought about it, did you ever actually separate?

Yes	1	7
No	2	8
		9

127. Suppose your marriage were to break up. I'm going to read you things that could be affected by a break-up, and for each one I'd like you to tell me who you think would be hurt more by it, you or your wife/husband?

	Respondent	Both hurt the Same	Spouse	Neither Hurt	
a. Who would be hurt more by being lonely	1	2	3	4	7 8 9
b. Who would be hurt more by having to do household chores	1	2	3	4	7 8 9
c. Who would be hurt more by not being able to get around as easily	1	2	3	4	7 8 9
d. Who would be hurt more financially	1	2	3	4	7 8 9
e. Who would be hurt more by a loss of friends	1	2	3	4	7 8 9
f. Who would be hurt more by angry or disappointed relatives	1	2	3	4	7 8 9

128. Every relationship has it's ups and down, and surveys like this have shown that at sometime or another, most people wonder about whether they should continue having contact with the other person. What about in your case? Have you ever thought about breaking off contact with (A/C?)

Yes...............1 7
No................2 8
9

a. IF YES, ASK: How much have you thought about it? Was it once, a few times or a lot?

Once..............1 7
A few times.......2 8
A lot.............3 9

b. When you thought about it, did you ever actually separate?

Yes...............1 7
No................2 8
9

Comments: ______________________________

129. Suppose you broke off contact with (A/C). I'm going to read you things that could be affected by a break-up, and for each one I'd like you to tell me who you think would be hurt more by it, you or (A/C).

	Respondent	Both hurt the Same	(A/C)	Neither Hurt	
a. Who would be hurt more by being lonely	1	2	3	4	7 8 9
b. Who would be hurt more by having to do household chores	1	2	3	4	7 8 9
c. Who would be hurt more by not being able to get around as easily	1	2	3	4	7 8 9
d. Who would be hurt more financially	1	2	3	4	7 8 9
e. Who would be hurt more by a loss of friends	1	2	3	4	7 8 9
f. Who would be hurt more by angry or disappointed relatives	1	2	3	4	7 8 9

130. Is your relationship with A/C now pretty much like it always has been?

Yes	1	7
No	2	8
		9

a. IF NO, ASK: How has it changed?

131. Do you feel that (A/C) owes you anything, in terms of care or support?

Yes...............1   7
No................2   8
9

a. Why or why not?

132. If you became seriously ill or disabled, would you consider moving into a nursing home?

Yes...............1   7
No................2   8
9

a. Why or why not?

133. IF (A/C) ELDERLY, DISABLED, OR ILL, ASK: If A/C became seriously ill or disabled, would you consider placing him or her in a nursing home?

Yes...............1   7
No................2   8
9

a. Why or why not?

134-136. Now, for statistical purposes, we need to know which of these groups your total family income before taxes for 1982 was in. Please include you own income and that of all members in your immediate family who are living with you, and any sources of income you may have.

	Q.134 FAMILY	Q.135 RESPONDENT	C.136 (AD/C)
LESS THAN $2,499	01	01	01
$2,500 TO $5,999	02	02	02
$6,000 TO $9,999	03	03	03
$10,000 TO $14,999	04	04	04
$15,000 TO $19,999	05	05	05
$20,000 TO $24,999	06	06	06
$25,0000 AND OVER	07	07	07
	77	77	77
	88	88	88
	99	99	99

135. Which of the groups on the card comes closest to your own annual income before taxes for 1982? Just what you, yourself, made last year.

136. What about (AD/C)'s income? Which group comes closest to her annual income before taxes for 1982?

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Now, I would like to ask you sime other questions about (A/C).

137. How would you rate his/her health at the present time?

Excellent.........1   7

Good..............2   8

Fair..............3   9

Poor..............4

138. Does he/she have any of the following conditions? IF YES, ASK: Is it a condition that limits what he/she is able to do?

IF YES, ASK: How much does it interfere with his/her activities..not at all..a little...or a great deal?

	No	If Yes, does it interfere		
		Not at all	Little	Great deal
		3	2	1
a. Arthritis or rheumatism				
b. Glaucoma				
c. Emphysema/Chronic Bronchitis				
d. Tuberculosis				
e. High blood pressure				
f. Circulation problems				
g. Diabetes				
h. Ulcers (digestive tract)				
i. Other stomach disorders				
j. Liver disease				
l. Urinary tract/Prostate				
m. Cancer or leukemia				
n. Anemia				
o. Effects of stroke				
p. Parkinson's disease				
q. Epilepsy				
r. Cerebral Palsy				
s. Multiple Sclerosis				
t. Multiple Dystrophy				
u. Thyroid/glandular disease				
v. Skin disorders/sores				
w. Speech Impediment				
x. Mental or Emotional Problem				
y. Other				

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139. Does (A/C) require assistance in any of his/her activities, such as bathing, dressing, preparing meals or getting around?

Yes....................1 7

No.....................2 8

9

140. IF YES, ASK: In what areas does he/she require assistance? Who provides it?

	Type of Assistance	Provider
a		
b		
c		
d		
e		
f		

141. In the past year, has (A/C) been admitted to an acute care hospital?

Yes....................1

No.....................2

a. If Yes, Ask: How many times? ___________

142. Has (A/C) ever been admitted to any other type of hospital or clinic, for example, psychiatric or chronic disease?

Yes....................1

No.....................2

a. Why was that?

143. Does A/C have any psychological or emotional problems?

Yes....................1

No.....................2

a. IF YES, ASK: What are these?

144. Have you noticed any major changes in (A/C's) mental or emotional condition over the past five years?

Yes....................1

No.....................2

a. If yes, ask: What are these?

____

____

____

____

145. Over the past year?

Yes....................1

No.....................2

a. What are these?

____

____

____

____

HAND RESPONDENT CARD A

145-147 No matter how well a couple gets along, there are times when they disagree on major decisions, get annoyed about something the other person does, or just have spats or fights because they're in a bad mood or tired or for some other reason. They also use many different ways of trying to settle their differences. I'm going to read a list of some things that you and your (relative) might have done when you had a dispute, and would first like you to tell me for each one how often you did it in the past year.

	Q. 145					Q. 146					Q. 147		
	RESPONDENT-IN PAST YEAR					RELATIVE-IN PAST YEAR					EVER HAPPENED		
	NEVER	ONCE OR TWICE	3-10 TIMES	11 OR MORE TIMES	DON'T KNOW	NEVER	ONCE OR TWICE	3-10 TIMES	11 OR MORE TIMES	DON'T KNOW	YES	NO	DON'T KNOW
a. Discussed the issue calmly	0	1	2	3	9	0	1	2	3	9	1	2	9
b. Got information to back up (your/her) side of things	0	1	2	3	9	0	1	2	3	9	1	2	9
c. Brought in or tried to bring in someone to help settle things	0	1	2	3	9	0	1	2	3	9	1	2	9
d. Insulted or swore at the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
e. Sulked and/or refused to talk about it	0	1	2	3	9	0	1	2	3	9	1	2	9
f. Stomped out of the room or house (or yard)	0	1	2	3	9	0	1	2	3	9	1	2	9
g. Cried	0	1	2	3	9	0	1	2	3	9	1	2	9
h. Did or said something to spite the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
i. Threatened to hit or throw something at the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
j. Threw or smashed or hit or kicked something	0	1	2	3	9	0	1	2	3	9	1	2	9
k. Threw something at the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
l. Pushed, grabbed, or shoved the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
m. Slapped the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
n. Kicked, bit or hit with a fist	0	1	2	3	9	0	1	2	3	9	1	2	9
o. Hit or tired to hit with something	0	1	2	3	9	0	1	2	3	9	1	2	9
p. Beat up the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
q. Threatened with a knife or gun	0	1	2	3	9	0	1	2	3	9	1	2	9
r. Used a knife or gun	0	1	2	3	9	0	1	2	3	9	1	2	9
s. Other (PROBE): ______________	0	1	2	3	9	0	1	2	3	9	1	2	9

146 And what about your (RELATIVE)? Tell me how often he/she (ITEM) in the past year.

FOR EACH ITEM CIRCLED EITHER "NEVER" OR "DON'T KNOW" FOR BOTH RESPONDENT AND PARTNER, ASK:

147 Did you or your (RELATIVE) ever (ITEM)? ______________________________

Note: If any bracketed items has ever happened, respondent is eligible for re-interview. Refer back to this page at the end of interview.

149. FOR MOST SEVERE ACTION IN Q. 146, ASK: You mentioned that you have _______ when you had a dispute with (A/C). Could you tell me more about what happened?

PROBE: Were you having an argument? About what? Was anyone else present?

What did (A/C) do when this happened? Had you or (A/C) been drinking when this occurred?

150. FOR MOST SEVERE ACTION IN Q. 147, ASK: You mentioned that (A/C) has _____ when you had a dispute with him/her. Could you tell me more about what happened?

PROBE: Were you having an argument? What about? Was anyone else present?

What did (A/C) do when this happened? Had you or (A/C) been drinking when this occurred?

151. FOR MOST SEVERE ACTION IN Q. 148, ASK: You mentioned that __________ has happened in your relationship. Could you tell me more about what has happened?

PROBE: Were you having an argument? About what? Was anyone else present?

What did (A/C) do when this happened? Had you or (A/C) been drinking when this occurred?

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152. Your name was suggested to us by (E.A. Worker) at (Agency). What kind of contact have you had with that agency?

a. What does (E.A. Worker) do for you?

b. Are you satisfied with your contact with (E.A. Worker)?

Yes..................1 7

No...................2 8

9

c. Why or why not?

153. That finishes up my questions for you. Do you have anything else you would like to add on any of the topics we've discussed?

154. We are asking everyone we interview if they would be willing to be interviewed again at a later date. Would it be possible for me to come back and talk with you again? The next time, our conversation would be more informal. You would be paid another ten dollars for your time.

Yes, willing to be re-interviewed 1 7
No, not willing to be re-interviewed 2 8
9

[Ask Q. 155-157 of Model Project Worker]

155. Based on your assessment, what type(s) of physical abuse has the respondent received?

156. Is the respondent disoriented?

Always 1 7
Sometimes. 2 8
Never. 3 9

157. Does the respondent have difficulty remembering recent events?

Always 1 7
Sometimes. 2 8
Never. 3 9

EXHIBIT 5

KIN INTERVIEW

COVER SHEET

1. Subject Number ____________________
2. Date of Interview ____________________
3. Time Interview Began ____________________
4. Place of Interview ____________________
5. Model Project Contact Person ____________________

Standard Codes for all items: Unknown = 9, 99, 999

Refused or non-responsive answer = 8, 88, 888

Not applicable = 7, 77, 777

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INFORMED CONSENT

We are currently conducting interviews with people over the age of 60, and members of their families. The purpose of our study is to find out about the lives of older people, and to understand their relationships with their relatives: what problems families have, for example, and what services they might need. We are expecially interested in how older people get along with their families. The family often is very helpful to older members, but living with or helping an elderly relative can also cause some strains. We hope to understand what it is like to have an elderly relative.

I want to assure you that your answers will be held strictly confidential. Your name will not appear anywhere on the questionnaire, so your answers cannot be connected with you in any way. You are one of 120 people who will be interviewed, and your answers will never be identified separately. I also want to make sure you understand that you may choose not to answer any question, and that you may end the interview at any time.

I CERTIFY THAT I HAVE READ THE ABOVE STATEMENT TO THE RESPONDENT AND THAT HE/SHE HAS UNDERSTOOD THIS STATEMENT AND HAS GIVEN PERMISSION TO CONDUCT THE INTERVIEW.

(INTERVIEWER)

(DATE)

DEMOGRAPHIC

I am going to start the interview with some general background questions about you and the people you live with.

1. Sex of Subject (interviewer note)

Male..................1

Female................2

2. Race of Subject (interviewer note)

White (Caucasian)......1

Black.................2

Oriental..............3

Hispanic..............4

Other.................5

3. When were you born?

_____ _____ _____
month day year

4. How far did you go in school?

0-6 years............. 01 77

7-9 years.............02 88

some high school.......03 99

high school graduate...04

some college or
vocational training....05

college graduate.......06

post graduate study....07

5. What is your marital status?

Single (never married)......1 7
Married.....................2 8
Widowed.....................3 9
Divorced....................4
Separated...................5

a. How many years in this status? ______________

6. About how many years have you lived at this address? ______________

7. Do you own your own home, pay rent, or what?

Own...............1 7
Rent..............2 8
Other.............3 9

Specify ______________________________

8. What countries or part of the world did your parents or grandparents come from?

____

9. What is your religious preference?

Catholic..........1 7
Protestant........2 8
Denomination __________ 9
Jewish 3
Other.............4

Specify ______________________________

10. Are you presently working full-time, part-time, retired, keeping house, unemployed or what?

Working full time.....1   7

Working part-time.....2   8

Retired...............3   9

Keeping house.........4

Unemployed............5

Other.................6

11. If working: what king of work do you do? ______________________________

a. What kind of work have you done most of your life?

____

12. IF DOES NOT LIVE WITH AD/C, ASK: Now, I'd like to find out who lives here with you. Could you tell me who lives here?

a. For each ask:

1. How are they related to you?
2. How old are they?
3. What is their marital status?
4. How many years in this status?

____

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RELATIONSHIP (OR CONNECTION) TO RESPONDENT	SEX	AGE	MARITAL STATUS	LENGTH OF TIME
RESPONDENT				

USE THESE CODES TO SHOW MARITAL STATUS OF EACH RESIDENT:

M=Married, S=Single, D=Divorced, W=Widowed, SP=Separated ________________

b. Total number in household ______________________

HEALTH AND FUNCTIONAL STATUS

Now, I'd like to ask you some questions about your health and your ability to get around.

13. How would you rate your overall health at the present time?

Excellent.........1   7

Good..............2   8

Fair..............3   9

Poor..............4

14. I'm going to read you a list of health problems that people sometimes experience. Do you have any of the following conditions? If YES, Ask: How much does it interfere with your activities: not at all, a little, or a great deal?

	If Yes, does it interfere		
	Not at all	Little	Great deal
	3	2	1
a. Arthritis or rheumatism			
b. Glaucoma			
c. Emphysema/Chronic Bronchitis			
d. Tuberculosis			
e. High blood pressure			
f. Circulation problems			
g. Diabetes			
h. Ulcers (digestive tract)			
i. Other stomach disorders			
j. Liver disease			
k. Urinary tract/Prostate			

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	3	2	1
l. Cancer or leukemia			
m. Anemia			
n. Effects of stroke			
o. Parkinson's disease			
p. Epilepsy			
q. Cerebral Palsy			
r. Multiple Sclerosis			
s. Multiple Dystrophy			
t. Thyroid/glandular disease			
u. Skin disorders/sores			
v. Speech Impediment			
w. Mental or Emotional Problem			
x. Other			

15. In the past year, have you been admitted overnight to an acute care hospital?

Yes...............1 7

No................2 8

9

16. If YES to Q. 24: How many times were you admitted?

____

17. Is your health now better, about the same, or worse than it was five years ago?

Better............1   7
About the same....2   8
Worse.............3   9

Explain: ______________________________

____

____

____

18. Is your health now better, about the same, or worse than it was one year ago?

Better............1   7
About the same....2   8
Worse.............3   9

Explain: ______________________________

____

____

____

SOCIAL SUPPORT

19. How many people do you know well enough to visit in their homes?

Five or more......3 7

Three to four.....2 8

One to two........1 9

None..............0

20. About how many times did you talk to someone--friends, relatives, or others--on the telephone in the past week (either you called them or they called you)?

Once a day or more.....3 7

2-6 times..............2 8

Once...................1 9

Not at all.............0

21. How many times in the past week did you spend some time with someone who does not live with you, that is you went out to see them or they came to visit you, or you went out to do things together?

Once a day or more.....3 7

2-6 times..............2 8

Once...................1 9

Not at all.............0

22. Do you have someone you can trust and confide in?

Yes................2 7

No.................0 8

9

23. Do you find yourself feeling lonely quite often, sometimes, or almost never?

Quite often.......0   7

Sometimes.........1   8

Almost never......2   9

24. Do you see your relatives and friends as often as you want to or are you somewhat unhappy about how little you see them?

As often as wants to.................1   7

Somewhat unhappy about how little....2   8

9

25. Is there someone who would give you any help at all if you were sick or disabled, for example, your husband/wife, a member of your family, or a friend?

Yes..................................1   7

No one willing and able to help....2   8

9

26. IF YES, ASK: Is there someone who would take care of you as long as needed, or only for a short time, or only someone who would help you now and then (for example, taking you to the doctor, or fixing lunch occasionally, etc)?

Someone who would take care of subject indefinitely (as long as needed)........................1   7

Someone who would take care of subject for a short time (a few weeks to six months)...............2   8

Someone who would help the subject now and then (taking him/her to the doctor, fixing lunch, etc).....3   9

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a. Who is this person?

Name ______________________________

Relationship ______________________________

27. Do you belong to a church, club or other organizations?

Yes................1 7

No.................2 8

9

a. IF YES, ASK: What are they? ______________________________

b. How frequently do you attend each of these? ______________________________

____

28. We have just been talking about your relationships with other people. Have these changed substantially in any way in the last five years (for example, do you see people less or more than you used to, or get more or fewer calls)?

Yes................1 7

No.................2 8

9

a. IF YES, ASK: Could you please explain?

b. If AD/C not mentioned, ASK: How about your relationship with AD/C?

29. How about in the last year?

Yes................1 7

No.................2 8

a. IF YES, ASK: Could you please explain?

[illegible]. If AD/C not mentioned, ASK: How about your relationship with (AD/C)?

STRESS

Every family experiences stress from time to time. I am now going to ask you some questions about what might cause stress in this household.

30. What do you find stressful in your life right now? (Probe: What do you tend to worry about?)

31. Sometimes financial problems can create stress. Is having enough money a problem for you?

Yes...............1 7

No................2 8 Comment: ______________________

9 ______________________

____

32. I am going to read a list of events which may have occurred in the life of someone living in this household. Please indicate those events which have occurred to someone here in the past year, and whom they may have happened to.

		IN LAST YEAR			
		Yes, Has Happened	Household Member	No, Has not Happened	
a.	Someone in the household died	1	________	2	7 8 9
b.	A close relative of someone in the household died	1	________	2	7 8 9
c.	Someone in the household has been ill or injured	1	________	2	7 8 9
d.	Someone in the household was divorced	1	________	2	7 8 9
e.	Someone in the household was married	1	________	2	7 8 9
f.	Someone in the household was arrested	1	________	2	7 8 9
g.	Someone left the household to move elsewhere	1	________	2	7 8 9
h.	Someone joined the household from somewhere else	1	________	2	7 8 9
i.	Someone in the household lost a job	1	________	2	7 8 9
j.	Someone in the household retired	1	________	2	7 8 9
k.	The household had to change residence	1	________	2	7 8 9

FOR EACH ANSWER "YES, HAS HAPPENED,"

PROBE: What was this like for you?

Did this event affect your relationship with (AD/C)?

LANGNER SCALE

Now, I would like to ask you some questions about how you have been feeling lately. Some of these questions may sound a little strange, but try to answer them as best you can.

33. I feel weak all over much of the time.

Yes....................1		7
No.....................2		8
		9

34. I have had periods of days, weeks, or months when I couldn't take care of things because I couldn't "get going."

Yes....................1		7
No.....................2		8
		9

35. In general, would you say that most of the time you are in high (very good) spirits, good spirits, low spirits, or very low spirits?

1. High.......1	7
2. Good.......2	8
3. Low........3	9
4. Very Low...4	

36. Every so often I suddenly feel hot all over.

Yes....................1		7
No.....................2		8
		9

37. Have you ever been bothered by your heart beating hard? Would you say: often, sometimes, or never?

Often..................1 7

Sometimes..............2 8

Never..................3 9

38. Would you say your appetite is poor, fair, good or too good?

Poor...................1 7

Fair...................2 8

Good...................3 9

Too Good...............4

39. I have periods of such great restlessness that I cannot sit still very long.

Yes....................1 7

No.....................2 8

9

40. Are you a worrier?

Yes....................1 7

No.....................2 8

9

41. Have you ever been bothered by shortness of breath when you were NOT exercising or working hard? Would you say: often, sometimes, or never?

Often..................1 7

Sometimes..............2 8

Never..................3 9

42. Are you ever bothered by nervousness (irritable, fidgety, tense)? Would you say: often, sometimes, or never?

Often....................1	7
Sometimes..............2	8
Never....................3	9

43. Have you ever had any fainting spells (lost consciousness)? Would you say: never, a few times, or more than a few times?

Never....................1	7
A few times............2	8
More than a few times..3	9

44. Do you ever have any trouble in getting to sleep or staying asleep?

Often....................1	7
Sometimes..............2	8
Never....................3	9

45. Are you bothered by acid stomach?

Yes......................1	7
No.......................2	8
	9

46. My memory seems to be good.

Yes......................1	7
No.......................2	8
	9

47. Have you ever been bothered by "cold sweats?"

Often..................1   7

Sometimes..............2   8

Never..................3   9

48. Do your hands ever tremble enough to bother you?

Often..................1   7

Sometimes..............2   8

Never..................3   9

49. There seems to be a clogging in my head or nose.

Yes....................1   7

No.....................2   8

9

50. I have personal worries that make me physically ill.

Yes....................1   7

No.....................2   8

9

51. Do you feel somewhat apart even among friends?

Yes....................1   7

No.....................2   8

9

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52. Nothing ever turns out for me the way I want it to.

Yes.....................1   7

No......................2   8

9

53. Are you ever troubled with headaches or pains in the head?

Often..................1   7

Sometimes..............2   8

Never..................3   9

54. I sometimes can't help wondering if anything is worthwhile anymore.

Yes.....................1   7

No......................2   8

9

HELP PROVIDED

55. Now think of all your friends and relatives and (AD/C)'s friends and relatives, including yourself. How many help him/her in any way at all?

Number of relatives ________________________.

a. For each of these relatives, could you tell me how they are related to (AD/C) and if they provide a lot of help, some help, or just a little help for him/her?

	A lot	Some	Little	
1. Respondent	3	2	1	7 8 9
2. ________	3	2	1	7 8 9
3. ________	3	2	1	7 8 9
4. ________	3	2	1	7 8 9
5. ________	3	2	1	7 8 9
6. ________	3	2	1	7 8 9

56. Are you the person whom (AD/C) depends on most and who actually helps him/her the most?

Yes....................2   7

Shared equally with
other person...........1   8

No.....................0   9

a. IF NO, ASK: Who is this other person? ______________________________

I'm going to ask some questions about the kinds of help you and other people have been giving (AD/C).

57. First, can you tell me about how many hours in an average week you spend doing things for or with (AD/C).

____

Now, I'm going to mention several different types of possible tasks. For each, I'd like to know if you help in that way, how much time is involved, and if it has been difficult for you to do these tasks.

58. Do you ever help AD/C by providing transportation or taking him/her to doctors, clinics, church, or other places?

Yes....................1   7

No.....................2   8

9

IF NO HELP GIVEN, GO TO NEXT SERVICE

IF HELP GIVEN, ASK:

a. How many round trips do you make each week? ______________________

b. Is doing this difficult for you?

Yes....................1 7

No.....................2 8

9

Comment ____

____

____

____

59. Do you help AD/C with housekeeping chores such as cleaning, doing the laundry, etc?

Yes....................1 7

No.....................2 8

9

IF NO HELP GIVEN, GO TO NEXT SERVICE

IF HELP GIVEN, ASK:

a. How many hours per week do you spend doing these chores? ______________

b. Is doing this difficult for you?

Yes....................1 7

No.....................2 8

9

Comments: ____

____

____

60. Do you ever prepare meals for (AD/C)?

Yes....................1 7

No....................2 8

9

IF NO HELP GIVEN, GO TO NEXT SERVICE

IF HELP GIVEN, ASK:

a. About how many meals do you prepare each week? ____________________

b. Is doing this difficult for you?

Yes....................1 7

No....................2 8

9

Comments: ____________________

____

____

____

61. Do you ever help AD/C by doing his/her food shopping or running other personal errands for him/her?

Yes....................1 7

No....................2 8

9

IF NO HELP GIVEN, GO TO NEXT SERVICE

12_2

IF HELP GIVEN, ASK:

a. How many hours a week would you say you spend doing this? ____________

b. Is doing this difficult for you?

Yes....................1 7

No.....................2 8

9

Comments: ____

____

____

62. Do you help AD/C with personal care, that is, with bathing, dressing, feeding, or toilet care?

Yes....................1 7

No.....................2 8

9

IF NO HELP GIVEN, GO TO NEXT SERVICE

IF HELP GIVEN, ASK:

a. How many hours would you say you spend on this? ____________

b. Is doing this difficult for you?

Yes....................1 7

No.....................2 8

9

Comments: ____

____

____

63. Do you help AD/C with health care (such as giving medication, changing bandages, taking blood pressure, or supervising physical exercises)?

Yes	1	7
No	2	8
		9

IF NO HELP GIVEN, GO TO NEXT SERVICE

IF HELP GIVEN, ASK:

a. How many hours per week would you say you spend doing this? ________

b. Is doing this difficult for you?

Yes	1	7
No	2	8
		9

Comments: ____________________

64. Do you help AD/C manage his/her money (for example, doing banking, paying bills)? (This does not include financial contributions).

Yes	1	7
No	2	8
		9

IF NO HELP GIVEN, GO TO NEXT SERVICE

124

IF HELP GIVEN, ASK:

a. How many hours a week would you say you spend doing this? ________

b. Is doing this difficult for you?

Yes....................1 7

No.....................2 8

9

Comments: ____

____

____

____

65. Do you help AD/C by dealing with the agencies he/she receives services from or by getting information about other services?

Yes....................1 7

No.....................2 8

9

IF NO HELP GIVEN, GO TO NEXT SERVICE

IF HELP GIVEN, ASK:

a. How many hours a week would you say you spend doing this? ________

b. Is doing this difficult for you?

Yes....................1

No.....................2

Comments: ____

____

____

____

66. Do you help (AD/C) by giving money or paying for his/her food, clothing, or medical expenses?

Yes....................1 7

No.....................2 8

9

a. IF YES, ASK: For the purposes of this study, it would be very helpful to us to know roughly how much you contribute in each area. Could you tell me if you contribute in any of the following areas, and if so, roughly the amount you contribute?

	Yes	No		Amount
1. Give money	1	2	7 8 9	___________
2. Pay for some of his/her food, clothing, or household items	1	2	7 8 9	___________
3. Pay of some of his/her medical expenses like doctor bills, medication, etc.	1	2	7 8 9	___________
4. Other	1	2	7 8 9	___________

IF NO HELP GIVEN, GO TO NEXT SERVICE

IF HELP GIVEN, ASK:

b. Is doing this difficult for you?

Yes....................1 7

No.....................2 8

9

Comments: ____

____

____

____

67. Do you help (AD/C) by just talking to him/her when s/he has a family problem or when s/he is feeling generally depressed?

Yes....................1 7

No....................2 8

9

IF NO HELP GIVEN, GO TO NEXT SERVICE

IF HELP GIVEN, ASK:

a. How many hours a week would you say you spend doing this? ___________

b. Is doing this difficult for you?

Yes....................1

No....................2

Comments: ____

____

____

____

68. Is there any other way you help AD/C that we have not talked about?

a. In what way?

b. How many hours a week do you spend doing this?

c. Is doing this difficult for you?

a. Type of help	b. Hours per week	c. Difficult
1.		Yes..1 No..2
2.		Yes..1 No..2
3.		Yes..1 No..2
4.		Yes..1 No..2

69. Which of the things you do to help do you find most difficult?

70. Which is the least difficult for you to do?

71. IF RESPONDENT APPEARS TO BE PRIMARY CAREGIVER, ASK: You seem to have the primary reponsibility for caring for AD/C. How did you come to get this responsibility, rather than any other relative?

72. Why do you provide the help you do?

PROBE FOR REASONS SUCH AS: Loves AD/C, Family should have responsibility for care, wants to repay past help, doesn't like nursing homes, no one else will, have no choice)

73. Would you way that helping (AD/C) involves no sacrifice, minor sacrifice, considerable sacrifice, or a major sacrifice for you?

No sacrifice..............	0	7
Minor sacrifice...........	1	8
Considerable sacrifice....	2	9
Major sacrifice...........	3	

Comments: ____

____

____

____

74. To what degree is helping AD/C stressful for you?

Not stressful at all......	0	7
Somewhat stressful........	1	8
Very stressful............	2	9

Comments ____

____

____

____________________ ____________________

75. I am going to read a list of things which other people have found to be difficult in helping out an elder person. Would you tell me whether any of these apply to you?

		YES	NO	NA
a)	Sleep is disturbed (e.g., because X is in and out of bed or wanders around at night, etc.)	1	2	7 8 9
b)	It is inconvenient (e.g., because helping takes so much time or its a long drive over to help, etc.)	1	2	7 8 9
c)	It is a physical strain (e.g., because of lifting in and out of chair, effort or concentration required, etc.)	1	2	7 8 9
d)	It is confining (e.g., helping restricts free time, can't visit, etc.)	1	2	7 8 9
e)	There have been family adjustments (e.g., because helping has disrupted routine, no privacy, etc.)	1	2	7 8 9
f)	There have been changes in personal plans (e.g., had to turn down a job, couldn't go on vacation, etc.)	1	2	7 8 9
g)	There have been other demands on my time (e.g., from other family members, etc.)	1	2	7 8 9
h)	There have been emotional adjustments (e.g., because of severe arguments, etc.)	1	2	7 8 9
i)	Some behavior is upsetting (e.g., because of incontinence, X has trouble remembering things, or X accuses people of taking things, etc.)	1	2	7 8 9
j)	It is upsetting to find X has changed so much from former self (e.g., is a different person than used to be, etc.)	1	2	7 8 9
k)	There have been work adjustments (e.g., because of having to take time off, etc.)	1	2	7 8 9
l)	It is a financial strain	1	2	7 8 9
m)	Feeling completely overwhelmed (e.g., because of worry about X, concerns about how will manage, etc.)	1	2	7 8 9
n)	Are there other kinds of things you find difficult that I haven't mentioned? (SPECIFY) ____________	1	2	7 8 9

____

____

______________________________ ____

130

(IF YES TO ANY OF THE ABOVE): Given the situation, what might make it easier for you go deal with it? Additional services? Additional income? More help from other relatives or friends? Change in attitude or behavior on part of (AD/C)?

FAMILY HISTORY

ASK Q 87-90 ONLY IF RESPONDENT IS CHILD OF AD/C, OR IF RAISED BY AD/C (E.G., GRANDCHILD CARED FOR BY AD/C)

Now, I'd like to talk about your family experience as a child and teenager and your relationship with your mother and father.

76. What was your family life like while you were growing up?

77. What was (AD/C) like as a person while you were growing up?

78. How would you describe your relationship with (AD/C) while you were growing up? Would you say it was?

Excellent.............3 7

Good..................2 8

Fair..................1 9

Poor..................0

79. Do you have any brothers or sisters? Yes. 1 7
No 2 8
9

a. IF RESPONDENT HAS SIBLINGS, ASK: How did your relationship to (AD/C) compare to his/her relationship with your brothers and sisters?

80. While you were growing up, would you say that (AD/C) made sacrifices for you and your family?

Many..................2 7

Some..................1 8

None..................0 9

81. During the time you were growing up, how much does each of these statements describe (AD/C)'s treatment of you?

	Never	Sometimes	Frequently	Usually	Always/ almost Always	
a. I could talk with him/her about everything	0	1	2	3	4	7 8 9
b. Comforted me and helped me when I had troubles	0	1	2	3	4	7 8 9
c. Taught me things which I wanted to learn	0	1	2	3	4	7 8 9
d. Helped me with things I didn't understand	0	1	2	3	4	7 8 9
e. When punishing me, explained why	0	1	2	3	4	7 8 9
f. Demanded that I believe as he/she wanted me to	0	1	2	3	4	7 8 9
g. Scolded and yelled at me	0	1	2	3	4	7 8 9
h. Hit or slapped me	0	1	2	3	4	7 8 9

82. Did you live with both your natural parents as a child and teenager?

Yes....................1 7

No.....................2 8

9

IF NO, ASK:

a. Were your natural parents divorced, separated, did one or both of them die, or was there some other reason you were not living with them as a child or teenager?

Divorced or Separated...............1 7

One died............................2 8

Both died...........................3 9

Respondent was adopted..............4

Other...............................5

Specify____

83. Were there any (any other) problems in your childhood or teenage years that you could tell me about?

84. How did your parents tend to discipline the children?

[ASK FOLLOWING QUESTIONS WHERE APPROPRIATE FOR FAMILY BACKGROUND]

85. Still thinking about when you were a child and teenager, about how often would you say your (mother/stepmother) used physical punishment, like slapping or hitting you? Think about the year in which this happened the most.

Never.................0 7
Once..................1 8
Twice.................2 9
3-5 times.............3
6-10 times............4
11-20 times...........5
More than 20 times....6

86. How about your (father/stepfather)? Again, thinking of the year in which it happened the most, how often would you say he used physical punishment in the course of a year?

Never.................0 7
Once..................1 8
Twice.................2 9
3-5 times.............3
6-10 times............4
11-20 times...........5
More than 20 times....6

87. Now, thinking about the whole time when you were child or teenager, were there occasions when your father/stepfather hit your mother or threw something at her?

Yes...............1 7
No................2 8
9

605

a. IF YES, ASK: How often did that happen?

Never.................0 7
Once..................1 8
Twice.................2 9
3-5 times.............3
6-10 times............4
11-20 times...........5
More than 20 times....6

88. What about your mother/stepmother hitting your father/stepfather? Were there occasions when that happened when you were a child or teenager?

Yes...............1 7
No................2 8
9

a. IF YES, ASK: How often did that happen?

Never.................0 7
Once..................1 8
Twice.................2 9
3-5 times.............3
6-10 times............4
11-20 times...........5
More than 20 times....6

89. Is there anything else you would like to tell me about your family background?

INTERPERSONAL RELATIONSHIPS

I would now like to ask you some questions about your living situation.

90. How satisfied are you with your current living situation?

Very satisfied........1   7

Somewhat satisfied....2   8

Somewhat unsatisfied..3   9

Very unsatisfied......4

a. Could you explain your answer?

91. IF LIVES WITH MORE THAN ONE OTHER PERSON, ASK: Whom do you get along best with in your living situation? ______________________

a. Why do you think this is?

92. IF LIVES WITH MORE THAN ONE OTHER PERSON, ASK: With whom do you get along least well in your living situation? ______________________

b. Why do you think this is?

93. How close do you feel now to (AD/C)? Would you say you are:

Very close............3 7

Somewhat close........2 8

Not too close.........1 9

Not close at all......0

94. How enjoyable is the time you and (AD/C) spend together? Why?

95. What kinds of things do you do together?

96. To what extent do you feel you are now dependent on (AD/C)?

Very much.............5 7

Considerably..........4 8

Some..................3 9

Very little...........2

Not at all............1

Comments:

97. IF RESPONDENT IS NOT SPOUSE, ASK: Since you have been an adult, has (AD/C) ever helped you by: READ LIST

IF YES, ASK: a. How important was this help to you at that time?

b. Do you currently depend on (AD/C) for this help?

	RECEIVED HELP		NO HELP	107(b)	
	Very Important (2)	Not that Important (1)	No Help (0)	Still Dependent (1)	
1. Giving or loaning you money	2	1	0	1	7 8 9
2. Starting you in business	2	1	0	1	7 8 9
3. Helping you financially with your education	2	1	0	1	7 8 9
4. Helping you with child care	2	1	0	1	7 8 9
5. Caring for you through a long illness	2	1	0	1	7 8 9
6. Providing you with housing	2	1	0	1	7 8 9
7. Helping you with household tasks (e.g., cooking, cleaning, laundry)	2	1	0	1	7 8 9
8. In any other say?	2	1	0	1	7 8 9

Specify__________

____

____

98. FOR EACH ITEM ANSWERED "STILL DEPENDENT," ASK: Does this dependence cause any problems for you? IF YES, ASK: Please explain.

99. IF 107(a)1 ANSWERED "YES", ASK: You mentioned that AD/C has assisted you financially. In what ways has he/she helped you?

PROBE: Giving you money? Paying for food, clothing, or household items? Paying medical expenses? Helping with house, car, or other large purchases?

a. Could you estimate the amount of financial help he/she has provided you in each of these areas?

IF A/C IS A SPOUSE, ASK Q. 110-111. IF A/C IS OTHER RELATIVE, ASK Q. 112-113

100. Every couple has their ups and downs, and surveys like this have shown that at some time or other, most people wonder about whether they should continue their marriage. What about in your case? Have you ever thought about this?

Yes....................1 7

No.....................2 8

9

610^{41-}

140 a. IF YES, ASK: How much have you thought about it? Was it once, a few times, or a lot?

Once.....................1 7

A few times..............2 8

A lot....................3 9

b. When you thought about it, did you ever actually separate?

Yes..................1 7

No...................2 8

9

101. Suppose your marriage were to break up. I'm going to read you things that could be affected by a break-up, and for each one I'd like you to tell me who you think would be hurt more by it, you or your wife/husband. First..

	Respondent	Both hurt the Same	Spouse	Neither Hurt	
a. Who would be hurt more by being lonely	1	2	3	4	7 8 9
b. Who would be hurt more by having to do household chores	1	2	3	4	7 8 9
c. Who would be hurt more by not being able to get around as easily	1	2	3	4	7 8 9
d. Who would be hurt more financially	1	2	3	4	7 8 9
e. Who would be hurt more by a loss of friends	1	2	3	4	7 8 9
f. Who would be hurt more by angry or disappointed relatives	1	2	3	4	7 8 9

102. Every relationship has it's ups and downs, and surveys like this have shown that at some time or other, most people wonder about whether they should continue having contact with the other person. What about in your case? Have you ever thought about breaking off contact with A/C?

Yes....................1 7

No.....................2 8

9

a. IF YES, ASK: How much have you thought about it? Was it once, a few times, or a lot?

Once...................1 7

A few times...........2 8

A lot.................3 9

b. When you thought about it, did you ever actually break off contact?

Yes....................1 7

No.....................2 8

9

Comments: ____

____

____

____

103. Suppose you broke off contact with (A/C). I'm going to read you things that could be affected by a break-up, and for each one I'd like you to tell me who you think would be hurt more by it, you or (A/C). First....

	Respondent	Both hurt the Same	(AD/C)	Neither Hurt	
a. Who would be hurt more by being lonely	1	2	3	4	7 8 9
b. Who would be hurt more by having to do household chores	1	2	3	4	7 8 9
c. Who would be hurt more by not being able to get around as easily	1	2	3	4	7 8 9
d. Who would be hurt more financially	1	2	3	4	7 8 9
e. Who would be hurt more by a loss of friends	1	2	3	4	7 8 9
f. Who would be hurt more by angry or disappointed relatives	1	2	3	4	7 8 9

104. Is your relationship with (AD/C) now pretty much like it always has been?

Yes..................1

No...................2

a. IF NO, ASK: How has it changed?

105. In general, do you feel like you give more than you get in this relationship?

Yes..................1 7

No...................2 8

9

a. Why or why not?

106. Do you feel as if you owe (AD/C) anything, in exchange for what he/she has given you in the past?

Yes..................1 7

No...................2 8

9

107. Do you feel AD/C owes you anyting, in terms of care or support?

Yes..................1 7

No...................2 8

9

a. Why or why not?

108. If you became seriously ill or disabled, would you consider moving into a nursing home?

Yes..................1 7

No...................2 8

9

109. If (AD/C) became seriously ill or disabled, would you consider placing him or her in a nursing home?

Yes..................1 7

No...................2 8

9

a. Why or why not?

110. IF OTHERS IN HOUSEHOLD ASK: Do any of the other people in this household make it easier or harder to get along with (AD/C)? How so?

111. For persons not living with spouse: Please tell me how you came to live here? (PROBE: What made you decide to live with (relative)).

HAND RESPONDENT CARD A

112-
114 No matter how well a couple gets along, there are times when they disagree on major decisions, get annoyed about something the other person does, or just have spats or fights because they're in a bad mood or tired or for some other reason. They also use many different ways of trying to settle their differences. I'm going to read a list of some things that you and your (relative) might have done when you had a dispute, and would first like you to tell me for each one how often you did it in the past year.

	Q 112 RESPONDENT-IN PAST YEAR					Q 113 RELATIVE-IN PAST YEAR					0 114 EVER HAPPENED		
	NEVER	ONCE OR TWICE	3-10 TIMES	11 OR MORE TIMES	DON'T KNOW	NEVER	ONCE OR TWICE	3-10 TIMES	11 OR MORE TIMES	DON'T KNOW	YES	NO	DON'T KNOW
a. Discussed the issue calmly	0	1	2	3	9	0	1	2	3	9	1	2	9
b. Got information to back up (your/her) side of things	0	1	2	3	9	0	1	2	3	9	1	2	9
c. Brought in or tried to bring in someone to help settle things	0	1	2	3	9	0	1	2	3	9	1	2	9
d. Insulted or swore at the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
e. Sulked and/or refused to talk about it	0	1	2	3	9	0	1	2	3	9	1	2	9
f. Stomped out of the room or house (or yard)	0	1	2	3	9	0	1	2	3	9	1	2	9
g. Cried	0	1	2	3	9	0	1	2	3	9	1	2	9
h. Did or said something to spite the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
i. Threatened to hit or throw something at the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
j. Threw or smashed or hit or kicked something	0	1	2	3	9	0	1	2	3	9	1	2	9
k. Threw something at the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
l. Pushed, grabbed, or shoved the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
m. Slapped the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
n. Kicked, bit or hit with a fist	0	1	2	3	9	0	1	2	3	9	1	2	9
o. Hit or tried to hit with something	0	1	2	3	9	0	1	2	3	9	1	2	9
p. Beat up the other one	0	1	2	3	9	0	1	2	3	9	1	2	9
q. Threatened with a knife or gun	0	1	2	3	9	0	1	2	3	9	1	2	9
r. Used a knife or gun	0	1	2	3	9	0	1	2	3	9	1	2	9
s. Other (PROBE): ______________	0	1	2	3	9	0	1	2	3	9	1	2	9

113 And what about your (RELATIVE)? Tell me how often he/she (ITEM) in the past year.

FOR EACH ITEM CIRCLED EITHER "NEVER" OR "DON'T KNOW" FOR BOTH RESPONDENT AND PARTNER, ASK:

114 Did you or your (RELATIVE) ever (ITEM)? ______________________________

Note: If any bracketed items has ever happened, respondent is eligible for re-interview. Refer back to this page at the end of interview.

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115. FOR MOST SEVERE ACTION IN Q. 112, ASK: You mentioned that ______________ has happened in your relationship. Could you tell me more about what has happened?

PROBE: Were you having an argument? About what? Was anyone else present?

Waht did (AD/C) do when this happened? Had you or (AD/C) been drinking when this occurred?

116. FOR MOST SEVERE ACTION IN Q. 113, ASK: You mentioned that (AD/C) has ____ when you had a dispute with him/her. Could you tell me more about what happened?

PROBE: Were you having an argument? What about? Was anyone else present?

What did (AD/C) do when this happened? Had you or (AD/C) been drinking when this occurred?

117. FOR MOST SEVERE ACTION IN Q. 146, ASK: You mentioned that you have ______ when you had a dispute with (AD/C). Could you tell me more about what happened?

PROBE: Were you having an argument? About what? Was anyone else present?

What did (AD/C) do when this happened? Had you or (AD/C) been drinking when thic occurred?

118-120. Now, for statistical purposes, we need to know which of these groups your total family income before taxes for 1982 was in. Please include your own income and that of all members in your immediate family who are living with you, and any sources of income you may have.

	0.118 FAMILY	0.119 RESPONDENT	0.120 WIFE/PARTNER
LESS THAN $2,499	01	01	01
$2,500 TO $5,999	02	02	02
$6,000 TO $9,999	03	03	03
$10,000 TO $14,999	04	04	04
$15,000 TO $19,999	05	05	05
$20,000 TO $24,999	06	06	06
$25,0000 AND OVER	07	07	07
	77	77	77
	88	88	88
	99	99	99

119. Which of the groups comes closest to your own annual income before taxes for 1982? Just what you, yourself, made last year.

120. What about your (AD/C)'s income? Which group comes closest to her annual income before taxes for 1982?

121. Your name was suggested to us by (E.A. Worker) at (Agency). What kind of contact have you had with that agency?

a. What does (E.A. Worker) do for you?

b. Are you satisfied with your contact with (E.A. Worker)?

Yes..............1 7

No...............2 8

9

c. Why or why not?

122. That finishes up my questions for you. Do you have anything else you would like to add on any of the topics we've discussed, or on any other issues?

123. We are asking everyone we interview if they would be willing to be interviewed again at a later date. Would it be possible for me to come back and talk with you again? The next time, our conversation would be more informal. You would be paid another ten dollars for your time.

Yes, willing to be re-interviewed 1 7
No, not willing to be re-inteviewed 2 8
9

[Ask Q. 120-126, of Model Project Worker]

124. To your knowledge, was the respondent abused as a child?

Yes 1 7
No. 2 8
9

125. To your knowledge, does respondent have any type of mental illness?

Yes 1 7
No. 2 8
9

126. To your knowledge, has respondent ever been hospitalized for psychiatric reasons?

Yes 1 7
No. 2 8
9

127. To your knowledge, has respondent ever been arrested?

Yes 1 7
No. 2 8
9

Please explain.

128. To your knowledge, has respondent committed acts of violence towards anyone other than AD/C?

Yes 1 7
No. 2 8
9

Please explain.

129. To your knowledge, does respondent abuse alcohol?

Yes 1   7
No. 2   8
9

Please explain.

130. To your knowledge, does respondent abuse drugs?

Yes 1   7
No. 2   8
9

Please explain.

EXHIBIT 6

PART ONE

THE NATURE OF YOUR WORK AND JOB

WE WOULD LIKE TO KNOW THE SPECIFIC KINDS of tasks and work activities that make up your job. Please describe below the types of tasks or work activities you have been performing regularly during the past three months. Briefly explain what each task is and indicate the numbers of hours each week you spend doing it.

Task 1: ______ **hours/week**

Task 2: ______ **hours/week**

Task 3: ______ **hours/week**

Task 4: ______ **hours/week**

Source: Van de Ven, Andrew H. and Diane L. Ferry.
Measuring and Assessing Organizations.
New York: Wiley, 1980

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Task 5: ______ **hours/week**

Task 6: ______ **hours/week**

Task 7: ______ **hours/week**

Task 8: ______ **hours/week**

1. Indicate the total number of hours per week you normally worked. Hours/week during the past three months: ______

PLEASE ANSWER THE FOLLOWING QUESTIONS BY THINKING ONLY ABOUT THE TYPES OF TASKS THAT OCCUPY MOST OF YOUR WORKING TIME.

2. *To what extent* do you perform the *same tasks* from day to day? (Circle a number below the scale.)

ALMOST ALL MY TASKS ARE THE SAME DAY-TO-DAY	MANY OF MY TASKS ARE THE SAME DAY-TO-DAY	ABOUT HALF MY TASKS ARE THE SAME DAY-TO-DAY	SOME OF MY TASKS ARE THE SAME DAY-TO-DAY	ALMOST NO TASKS ARE THE SAME DAY-TO-DAY
1	2	3	4	5

3. *How much the same* are the day-to-day situations, problems, or issues you encounter in performing your major tasks? (Circle a number below.)

VERY MUCH THE SAME	MOSTLY THE SAME	QUITE A BIT DIFFERENT	VERY MUCH DIFFERENT	COMPLETELY DIFFERENT
1	2	3	4	5

4. *How easy* is it for you to *know* whether you do your work correctly?

VERY DIFFICULT	QUITE DIFFICULT	SOMEWHAT EASY	QUITE EASY	VERY EASY
1	2	3	4	5

5. *What percent of the time* are you *generally sure* of what the *outcomes* of your work efforts will be?

40% OR LESS	41–60%	61–75%	76–90%	91% OR MORE
1	2	3	4	5

6. During a normal week, *how frequently* do *exceptions arise* in your work which require *substantially different* methods or procedures for doing it?

VERY RARELY	OCCASIONALLY	QUITE OFTEN	VERY OFTEN	CONSTANTLY
1	2	3	4	5

7. In the past 3 months, *how often* did *difficult problems arise* in your work for which there were no immediate or apparent solutions?

ONCE A WEEK OR LESS	ABOUT 2–4 TIMES A WEEK	ABOUT ONCE A DAY	ABOUT 2–4 TIMES A DAY	5 TIMES OR MORE A DAY
1	2	3	4	5

8. About *how much time* did you spend solving these *work problems*?

LESS THAN 1 HOUR/WEEK	ABOUT 1–4 HOURS/WEEK	ABOUT 1 HOUR/DAY	ABOUT 2–3 HOURS/DAY	4 HOURS OR MORE PER DAY
1	2	3	4	5

9. To what extent does *just your work alone* give you many *clues* to figure out *how well you are doing* your job (without relying on feedback from your supervisor or co-workers)?

MY WORK GIVES ME NO CLUES ON HOW WELL I DO MY JOB	MY WORK GIVES A FEW CLUES ON MY JOB PERFORMANCE	MY WORK GIVES SOME CLUES ON MY JOB PERFORMANCE	MY WORK GIVES MANY CLUES ON MY JOB PERFORMANCE	MY WORK GIVES ALL CLUES NEEDED TO KNOW HOW WELL I DO MY JOB
1	2	3	4	5

10. During the past 3 months, *how often* did you receive *suggestions or feedback* from your *co-workers* on your work?

NOT ONCE	ABOUT ONCE A MONTH	ABOUT ONCE A WEEK	ABOUT EVERY DAY OR SO	SEVERAL TIMES A DAY
1	2	3	4	5

11. *How many hours per week on or off the job* do you spend in some kind of *reading or training* to keep current in the skills needed to do your job?

LESS THAN 1 HR/WK	ABOUT 1–3 HR/WK	ABOUT 4–6 HR/WK	ABOUT 7–9 HR/WK	ABOUT 10 HR/WK OR MORE
1	2	3	4	5

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12. Describe the specific kinds of training programs or reading materials you spent this time on to remain current in your job.

____

____

____

____

13. When you *began* this job, *how long a period of orientation and training* did you receive that was *directly related to your job*?

A FEW HOURS OR LESS	ABOUT A DAY	ABOUT A WEEK	ABOUT A MONTH	MORE THAN A MONTH
1	2	3	4	5

14. How many *years* of academic, vocational, or professional *education* have you obtained *beyond high school*?

YEARS AFTER HIGH SCHOOL									
0	1	2	3	4	5	6	7	8	9

15. What is the highest educational degree you obtained in school?

GRADE SCHOOL DIPLOMA	HIGH SCHOOL DIPLOMA	VOCATIONAL OR CRAFT CERTIFICATION	COLLEGE BACHELOR'S DEGREE	MASTER'S DEGREE	DOCTORAL DEGREE
1	2	3	4	5	6

16. Indicate the *specific major* or *field of specialization* in which you obtained this degree.

____

17. *How often* do you follow about the *same work methods or steps* for *doing* your major tasks *from day to day*?

VERY SELDOM	SOMETIMES	ABOUT HALF THE TIME	QUITE OFTEN	VERY OFTEN
1	2	3	4	5

18. To what *extent* did you follow *standard operating procedures* or practices to do your major tasks the past 3 months?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	GREAT EXTENT	VERY GREAT EXTENT
1	2	3	4	5

19. *How many written rules and procedures exist* for doing your major tasks?

VERY FEW IF ANY	A SMALL NUMBER	A MODERATE NUMBER	A LARGE NUMBER	A GREAT NUMBER
1	2	3	4	5

20. *How precisely* do these rules and procedures *specify* how your major tasks are to be done?

VERY GENERAL	MOSTLY GENERAL	SOMEWHAT SPECIFIC	QUITE SPECIFIC	VERY SPECIFIC
1	2	3	4	5

21. *How heavy* was your *work load* during the past 3 months?

OFTEN NOT ENOUGH TO KEEP ME BUSY	SOMETIMES NOT ENOUGH TO KEEP ME BUSY	JUST ABOUT THE RIGHT AMOUNT	HARD TO KEEP UP WITH	ENTIRELY TOO MUCH FOR ME TO HANDLE
1	2	3	4	5

22. *How far in advance* do you generally *know* how much work will be required of you?

ABOUT AN HOUR OR LESS IN ADVANCE	ABOUT A DAY IN ADVANCE	ABOUT A WEEK IN ADVANCE	ABOUT A MONTH IN ADVANCE	ABOUT 6 MONTHS OR MORE IN ADVANCE
1	2	3	4	5

23. During the past 3 months, how much *control* did you have in setting the *pace* of your work?

NONE	VERY LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

24. When considering the various situations that arise in performing your work, what *percent of the time* do you *have* written or unwritten procedures for dealing with them?

0–20%	21–40%	41–60%	61–80%	81–100%
1	2	3	4	5

25. Listed below are four common decisions about your work. *How much authority* do you have in making each of the following decisions about your work:

	AMOUNT OF AUTHORITY I HAVE IN EACH DECISION				
	NONE	LITTLE	SOME	QUITE A BIT	VERY MUCH
a. Determining *what* tasks I will perform from day to day?	1	2	3	4	5
b. *Setting quotas* on how much work I have to complete?	1	2	3	4	5
c. *Establishing rules and procedures* about *how* my work is to be done?	1	2	3	4	5
d. Determining *how work exceptions* are to be handled?	1	2	3	4	5

26. How *much* does your *supervisor hold you personally accountable* for the *work decisions* you make in your job?

NOT AT ALL	VERY LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

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27. *How clearly* do you *know what level of work performance* is *expected* from you (in terms of amount, quality, and timeliness of output)?

VERY UNCLEAR	QUITE UNCLEAR	SOMEWHAT CLEAR	QUITE CLEAR	VERY CLEAR
1	2	3	4	5

28. How *clearly* does your *job description specify* the *standards of performance* on which your job is evaluated?

THERE IS NO JOB DESCRIPTION FOR MY JOB.	MY JOB DESCRIPTION DOES NOT STATE ANY PERFORMANCE STANDARDS TO BE ACHIEVED IN THIS JOB.	MY JOB DESCRIPTION IS VERY GENERAL IN STATING WHAT PERFORMANCE STANDARDS ARE TO BE ACHIEVED.	MY JOB DESCRIPTION IS QUITE CLEAR IN STATING WHAT PERFORMANCE STANDARDS ARE TO BE ACHIEVED.	MY JOB DESCRIPTION IS VERY CLEAR AND PRECISE IN STATING WHAT PERFORMANCE STANDARDS ARE TO BE ACHIEVED.
1	2	3	4	5

29. To what degree has your *supervisor discussed* with *you* these *performance standards* on which your job is evaluated?

MY SUPERVISOR NEVER DISCUSSED THEM WITH ME.	MY SUPERVISOR ONLY MENTIONED THEM TO ME VERY GENERALLY AND DID NOT CLARIFY THEM.	MY SUPERVISOR DISCUSSED THEM WITH ME QUITE SPECIFICALLY AND CLEARLY.	MY SUPERVISOR DISCUSSED THEM WITH ME IN A VERY DETAILED AND CLEAR WAY.
1	2	3	4

30. *How hard* is it to *attain* the *level of performance* that is *expected* from you?

I DON'T KNOW WHAT'S EXPECTED OF ME.	QUITE EASY	QUITE HARD	VERY HARD BUT ATTAINABLE	EXCESSIVELY HARD AND IMPOSSIBLE TO ATTAIN
1	2	3	4	5

31. To what extent do *you believe* that the *performance standards* upon which your work is evaluated are *fair*?

I DON'T KNOW WHAT STANDARDS ARE USED TO EVALUATE MY WORK.	VERY UNFAIR	SOMEWHAT FAIR	QUITE FAIR	VERY FAIR
1	2	3	4	5

32. *How much* does your *supervisor hold you personally responsible* for achieving these *performance standards* for your job?

NOT AT ALL	VERY LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

33. During the *past year, how often did* your immediate *supervisor discuss* your *work performance with you*?

NOT ONCE	ABOUT 1–4 TIMES A YEAR	ABOUT ONCE A MONTH	ABOUT ONCE A WEEK	ABOUT EVERY DAY OR SO
1	2	3	4	5

34. When your work performance was discussed with you, how often did you receive *practical suggestions* for improving your work?

NEVER	SELDOM	ABOUT HALF THE TIME	OFTEN	EVERY TIME
1	2	3	4	5

35. *If you attain* the *performance level* that is expected of you, *how likely is it that* each of the following *will happen*:	NO CHANCE	SMALL CHANCE	50% CHANCE	QUITE LIKELY	ALMOST A CERTAINTY
a. You will be *recognized* for your good work (e.g., given a special word of appreciation or given a pat-on-the-back)?	1	2	3	4	5
b. You will be given a *promotion* in this organization?	1	2	3	4	5

36. *If you do not attain* the *performance level* that is expected of you, *how likely is it that each* of the following *will happen*:	NO CHANCE	SMALL CHANCE	50% CHANCE	QUITE LIKELY	ALMOST A CERTAINTY
a. You will be reprimanded, or told to improve your work?	1	2	3	4	5
b. You will be demoted in this organization?	1	2	3	4	5

YOUR FEELINGS ABOUT YOUR JOB

NOW WE WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT HOW YOU PERSONALLY FEEL ABOUT YOUR JOB.

37. *How satisfied* are you with each of the following:	VERY UNSATISFIED	QUITE UNSATISFIED	SOMEWHAT SATISFIED	QUITE SATISFIED	VERY SATISFIED
a. Your job?	1	2	3	4	5
b. Your supervisor?	1	2	3	4	5

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	VERY UNSAT-ISFIED	QUITE UNSAT-ISFIED	SOME-WHAT SATIS-FIED	QUITE SATIS-FIED	VERY SATIS-FIED
c. Your pay?	1	2	3	4	5
d. The friendliness and cooperativeness of your *co-workers*?	1	2	3	4	5
e. The *career progress* you have made in this organization up to now?	1	2	3	4	5
f. Your chances for *career advancement* in this organization *in the future*?	1	2	3	4	5

	NONE	A LITTLE	SOME	QUITE A BIT	VERY MUCH
38. *How much effort* do you put into your work?	1	2	3	4	5
39. *How much* did you try *to improve* your job performance in the past 3 months?	1	2	3	4	5

40. Each of the statements below is something that a person might say about his or her job. Please indicate your own, personal *feelings* about your job by circling a number on the scale to the right of each statement to indicate how much you agree or disagree with each statement.

	DISAGREE STRONGLY	DISAGREE SOMEWHAT	NEUTRAL	AGREE-SOME-WHAT	AGREE STRONGLY
a. It's hard, on this job, for me to care very much about whether or not the work gets done right.	1	2	3	4	5
b. My opinion of myself goes up when I do this job well.	1	2	3	4	5
c. My supervisor often lets me know how well I am performing my job.	1	2	3	4	5
d. I feel a great sense of personal accomplishment when I do this job well.	1	2	3	4	5

	DISAGREE STRONGLY	DISAGREE SOMEWHAT	NEUTRAL	AGREE-SOME-WHAT	AGREE STRONGLY
e. I feel a very high degree of *personal responsibility for the work I do on this job.*	1	2	3	4	5
f. I frequently think of quitting this job.	1	2	3	4	5
g. I feel bad and unhappy when I discover that I have performed poorly on this job.	1	2	3	4	5
h. My co-workers on this job almost *never* give me any "feedback" about how well I am doing on my work.	1	2	3	4	5
i. I feel I should personally take the credit or blame for the results of my work on this job.	1	2	3	4	5
j. My own feelings generally are *not* affected much one way or the other by how well I do on this job.	1	2	3	4	5
k. I am recognized and rewarded for putting in additional effort to do superior work in this job.	1	2	3	4	5
l. I am reprimanded or told to "shape up" when I do inferior work in this job.	1	2	3	4	5

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83.

84. During the past 3 months, to what *extent* did you experience *problems* in coordinating work activities:	TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	LARGE EXTENT	VERY GREAT EXTENT
a. Between you and unit members?	1	2	3	4	5
c. With people outside of your unit?	1	2	3	4	5

HOW OFTEN RECEIVED OR SENT WRITTEN REPORTS OR MEMOS IN PAST 3 MONTHS

85. To coordinate the work of your unit during the past 3 months, *how often* were *written reports or memos* sent or received:	NOT ONCE	ABOUT 1–3 TIMES A MONTH	ABOUT 1–3 TIMES A WEEK	ABOUT 1–3 TIMES A DAY	ABOUT EVERY HOUR
a. Between you and unit members?	1	2	3	4	5
c. Between you and people outside of your unit?	1	2	3	4	5

HOW OFTEN HAD WORK DISCUSSIONS IN PAST 3 MONTHS

86. During the past 3 months, *how often did* work-related *discussions* (*face-to-face or by telephone*) occur on a one-to-one basis:	NOT ONCE	ABOUT 1–3 TIMES A MONTH	ABOUT 1–3 TIMES A WEEK	ABOUT 1–3 TIMES A DAY	ABOUT EVERY HOUR
a. Between your and unit members?	1	2	3	4	5
c. Between you and people outside your unit?	1	2	3	4	5

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	HOW OFTEN MEETINGS WERE HELD IN PAST THREE MONTHS					
	NOT ONCE	ABOUT ONCE A MONTH	ABOUT EVERY 2 WEEKS	ABOUT ONCE A WEEK	ABOUT 2–4 TIMES A WEEK	ONCE A DAY OR MORE
87. *How frequently* did you conduct *regularly scheduled staff or unit meetings* with your immediate subordinates during the past 3 months?	1	2	3	4	5	6
88. During the past 3 months, *how frequently* were you involved in *impromptu, unscheduled meetings to solve specific work problems*:						
a. With your subordinates?	1	2	3	4	5	6
b. With two or more people from outside of your unit?	1	2	3	4	5	6

	HOW OFTEN DISAGREEMENTS OR ARGUMENTS OCCURRED					
89. During the past 3 months, how often were there disagreements or arguments:	NOT ONCE	ABOUT ONCE A MONTH	ABOUT EVERY 2 WEEKS	ABOUT ONCE A WEEK	SEVERAL TIMES A WEEK	EVERY DAY
a. Between you and unit members?	1	2	3	4	5	6
c. Between you and people in other units?	1	2	3	4	5	6

	HOW OFTEN DISPUTES RESOLVED THIS WAY				
90. When these disagreements or disputes occurred, *how often were they handled* in *each* of the following ways during the past three months:	ALMOST NEVER	SELDOM	ABOUT HALF THE TIME	OFTEN	VERY OFTEN
a. By ignoring or avoiding the issues?	1	2	3	4	5
b. By smoothing over the issues?	1	2	3	4	5
c. By bringing the issues out in the open and working them out among the parties involved?	1	2	3	4	5
d. By having a higher-level supervisor resolve the issues between units?	1	2	3	4	5

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91. Overall, to what *extent* does this *conflict resolution help or hinder* your unit's performance?

HINDERS PERFORMANCE A LOT	HINDERS MORE THAN HELPS	NEITHER HELPS NOR HINDERS	HELPS MORE THAN HINDERS	HELPS PERFORMANCE A LOT
1	2	3	4	5

92. *How much* are unit *members willing to give other members the support* they need to do a good job?

NONE	LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

A SELF-APPRAISAL OF YOUR UNIT

NOW MAKE A SELF-ASSESSMENT OF THE ORGANIZATION AND EFFECTIVENESS OF YOUR UNIT. HOPEFULLY, THE QUESTIONS YOU HAVE ANSWERED SO FAR STIMULATED YOU TO MAKE SUCH A SELF-ASSESSMENT.

A. Describe the major *strengths* of your work unit.

____

____

____

____

____

____

B. Describe the major *weaknesses* of your work unit.

____

____

____

____

____

____

C. Describe the *specific organizational changes* you think are necessary to *improve* the effectiveness of your unit.

____

____

____

____

____

____

FINALLY, PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOURSELF. YOUR ANSWERS ARE USEFUL FOR STATISTICAL ANALYSIS AND ARE STRICTLY CONFIDENTIAL.

94. *How long* have you *worked in this organization*?

LESS THAN 6 MONTHS	6 MONTHS-2 YEARS	3–5 YEARS	6–10 YEARS	MORE THAN 10 YEARS
1	2	3	4	5

95. List below the *positions* or *job titles* you have held since you began working for this organization.

Indicate the *months* and *years* during which you held each position.

1. ____________________ From ____ to ____
2. ____________________ From ____ to ____
3. ____________________ From ____ to ____
4. ____________________ From ____ to ____
5. ____________________ From ____ to ____
6. ____________________ From ____ to ____

96. List below the *positions or job titles* you have held *before* you began working for this organization (if any).

1. ____________________ From ____ to ____
2. ____________________ From ____ to ____
3. ____________________ From ____ to ____
4. ____________________ From ____ to ____
5. ____________________ From ____ to ____
6. ____________________ From ____ to ____

98. Indicate your sex: Female ____ (1) Male ____ (2)

99. How old were you on your last birthday? ____ Years old.

100. How many dependents do you have? (You and others who depend on your income for their financial support.) ____ Number of dependents.

1. NAMES OF KEY OTHER UNITS	2. REASONS FOR RELATIONSHIP WITH OTHER UNIT	3. IMPORTANCE
write the *names of the most important other units* that your your unit had to coordinate with during the past 6 months. (Select up to five of the most important other units.) Other agencies	State as clearly as possible the *reasons why* your unit had to coordinate or work with this other unit during the past six months.	*How important* was this other unit in attaining the goals of your unit the past 6 months? (Write a number from scale below) 1 = NOT VERY IMPORTANT 2 = SOMEWHAT IMPORTANT 3 = QUITE IMPORTANT 4 = VERY IMPORTANT 5 = ABSOLUTELY CRUCIAL
Unit 1 ☐☐☐ 1 1 2 3 4		
Unit 2 ☐☐☐ 2 1 2 3 4		
Unit 3 ☐☐☐ 3 1 2 3 4		
Unit 4 ☐☐☐ 4 1 2 3 4		
Unit 5 ☐☐☐ 5 1 2 3 4		

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IN THE COLUMNS ON THE RIGHT, PLEASE WRITE THE NAME OF THE FIVE OTHER UNITS THAT YOU SELECTED ON THE PREVIOUS PAGE. THEN ANSWER THE FOLLOWING QUESTIONS FOR EACH OTHER UNIT INDIVIDUALLY BY WRITING IN THE APPROPRIATE COLUMN THE MOST ACCURATE NUMBER FROM THE ANSWER SCALE FOR EACH QUESTION.

	NAME: **UNIT 1**	**NAME:** **UNIT 2**	**NAME:** **UNIT 3**	**NAME:** **UNIT 4**	**NAME:** **UNIT 5**
c. Do you have a *contractual relationship* with this other unit?	No Yes	No Yes	No Yes	No Yes	No Yes
d. Is it *mandatory by government regulations* that you coordinate with this other unit?	No Yes	No Yes	No Yes	No Yes	No Yes
5. During the past six months, *how much* was your unit involved with this other unit for *each* of the following *reasons*: (use scale below)					
a. To receive or send *work or clients* (e.g., customers, raw materials, or work objects)?	______	______	______	______	______
b. To receive or send *resources* (money, personnel, equipment, office space)?	______	______	______	______	______
c. To receive or send *technical assistance* (e.g., consultation or staff services in functional areas)?	______	______	______	______	______
d. To receive or send *information* for purposes of coordination, control, planning, or evaluation?	______	______	______	______	______

NOT AT ALL	A LITTLE	SOME-WHAT	QUITE A BIT	VERY MUCH
1	2	3	4	5

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6. To what *extent* have the *terms of the relationship* between your unit and this other unit:
   a. Been explicitly *verbalized or dicussed*?
   b. Been *written down in detail*?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSIDERABLE EXTENT	GREAT EXTENT
1	2	3	4	5

7. For *how many years* has your unit been directly involved in some fashion with this other unit?

8. *Prior to* the *past six months*, to what extent has your unit had *effective working relationships* with this other unit?
(Write best scale number in each column)

NO PRIOR CONTACT	TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSIDER-ABLE EXTENT	GREAT EXTENT
0	1	2	3	4	5

9. For this *other unit* to accomplish its goals and responsibilities, *how much* does *it need* the *services, resources,* or *support from your unit*?

NOT AT ALL	VERY LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

10. For *your unit* to accomplish its goals and responsibilities, *how much do you need* the *services, resources,* or *support from this other unit*? (Use scale for Question 9.)

UNIT 1	UNIT 2	UNIT 3	UNIT 4	UNIT 5
Extent: ____ ____	Extent: ____ ____	Extent: ____ ____	Extent: ____ ____	Extent: ____ ____
____Yrs	____Yrs	____Yrs	____Yrs	____Yrs.
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____

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PLEASE CONTINUE TO ANSWER THE FOLLOWING QUESTIONS FOR EACH OF THE OTHER UNITS IN THE RIGHT COLUMNS, REMEMBERING TO USE THE SAME UNIT NUMBER AS THAT ON THE PREVIOUS PAGE.

11. How well *informed are you* about the specific goals and services of this other unit?

NOT AT ALL	LITTLE INFORMED	SOMEWHAT INFORMED	QUITE INFORMED	VERY WELL INFORMED
1	2	3	4	5

12. How much *say or influence* does this *other unit* have on the internal operations of your unit?

NONE	LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

13. How much *say or influence* does your unit have on the internal operations of this other unit? (Use scale for Question 12.)

UNIT 1	UNIT 2	UNIT 3	UNIT 4	UNIT 5
___	___	___	___	___
___	___	___	___	___
___	___	___	___	___

14. Write the *name* and *address* of the *primary* individual that you contact or communicate with when dealing with this other unit.

UNIT 1: Name: Address:

UNIT 2: Name: Address:

UNIT 3: Name: Address:

UNIT 4: Name: Address:

UNIT 5: Name. Address:

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	UNIT 1	UNIT 2	UNIT 3	UNIT 4	UNIT 5
15. How *many years* and *months* have *you personally* known the *contact person* in this other unit?	_____Years _____Months	_____Years _____Months	_____Years _____Months	_____Years _____Months	_____Years _____Months
16. *How well* are you *personally acquainted* with the *contact person* in this other unit?	_____	_____	_____	_____	_____
NO PERSONAL ACQUAINTANCE 1 NOT VERY WELL 2 SOMEWHAT WELL 3 QUITE WELL 4 VERY WELL 5					
17. *How much* do you and this contact person *agree* or disagree on:					
a. The *goal priorities* of your unit?	_____	_____	_____	_____	_____
b. The specific *ways* work is done or services are provided by your unit?	_____	_____	_____	_____	_____
c. The specific *terms of the relationship* between your unit and this other unit?	_____	_____	_____	_____	_____
DON'T KNOW 0 DISAGREE MUCH 1 AGREE A LITTLE 2 AGREE SOMEWHAT 3 AGREE QUITE A BIT 4 AGREE VERY MUCH 5					
18. To what extent does this other unit:					
a. Obtain its *funding* from the *same source* as your unit does?	_____	_____	_____	_____	_____
b. Do the *same kind of work* as your unit does?	_____	_____	_____	_____	_____
c. Have the same *clients or customers* as your unit?	_____	_____	_____	_____	_____
d. Have *operating goals similar* to your unit's goals?	_____	_____	_____	_____	_____

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e. Have *employees* with *similar professional or trade skills* as those required of personnel in your unit?

f. Use the *same technology, equipment, or information sources* as your unit in doing its work?

DON'T KNOW	TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSIDERABLE EXTENT	GREAT EXTENT
0	1	2	3	4	5

19. To what extent did individuals in this other unit *hinder* your unit in performing its functions during the past six months?
(Use scale for Question 18 above.)

20. Consider now the *equality* of the give-and-take relationship with each unit. Compared to other units that you are involved with, *how fair* do you feel are the "*payoffs*" *to your unit* from this unit?

WE GET MUCH LESS THAN WE OUGHT	WE GET SOMEWHAT LESS THAN WE OUGHT	BALANCED	WE GET SOMEWHAT MORE THAN WE OUGHT	WE GET MUCH MORE THAN WE OUGHT
1	2	3	4	5

21. During the past six months, *how frequently* have people in your unit *communicated or been in contact* with people in this other unit?

NOT ONCE	1-2 TIMES	ABOUT MONTHLY	ABOUT EVERY 2 WEEKS	ABOUT WEEKLY	ABOUT DAILY	MANY TIMES DAILY
0	1	2	3	4	5	6

UNIT 1	UNIT 2	UNIT 3	UNIT 4	UNIT 5
___	___	___	___	___
___	___	___	___	___
___	___	___	___	___
___	___	___	___	___
___	___	___	___	___

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	UNIT 1	UNIT 2	UNIT 3	UNIT 4	UNIT 5
22. Specifically, *how frequently* did your unit *communicate* with this other unit *through each* of the following ways during the past six months:					
a. Through *written letters, memos, or reports* of any kind?	____	____	____	____	____
b. Through *personal face-to-face discussions*?	____	____	____	____	____
c. Through *telephone* calls?	____	____	____	____	____
d. Through *group or committee meetings* between three or more people from your unit and this other unit? (Use scale for Question 21.)	____	____	____	____	____
23. In general, what *percent* of all these communications with this other unit were *initiated by* people in your unit during the past six months? (Indicate percent.)	____%	____%	____%	____%	____%
24. Overall, how much *difficulty* do you experience in *getting ideas clearly across* to individuals in this other unit when you communicate with them?	____	____	____	____	____

NO CONTACT	NONE	LITTLE	SOME	QUITE A BIT	VERY MUCH
0	1	2	3	4	5

	UNIT 1	UNIT 2	UNIT 3	UNIT 4	UNIT 5
25. When you wanted to communicate with individuals in this unit, how much *difficulty* have you had *getting in touch* with them? (Use scale for Question 24.)	____	____	____	____	____

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29. To what *extent* did your unit *encounter interruptions or delays* to the *normal flows* of work, resources, or services from or to this other unit during the past six months?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	MUCH EXTENT	VERY GREAT EXTENT
1	2	3	4	5

30. During the past six months, *how often* did *exceptions or problems arise* in sending or receiving work, resources, or services to or from this other unit?

NOT ONCE	1 OR 2 TIMES	ABOUT MONTHLY	ABOUT WEEKLY	ABOUT DAILY	SEVERAL TIMES A DAY
1	2	3	4	5	6

31. To coordinate activities with this other unit during the past six months, *to what extent*:

a. Have *standard operating procedures been established* (e.g., rules, policies, forms, etc.)?

b. Are *formal* communication *channels followed*?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSIDERABLE EXTENT	GREAT EXTENT
1	2	3	4	5

32. During the past six months, *how often* were there *disagreements or disputes* between people in your unit and this other unit?

NOT ONCE	ABOUT ONCE A MONTH	ABOUT EVERY 2 WEEKS	ABOUT ONCE A WEEK	SEVERAL TIMES A WEEK	EVERY DAY
1	2	3	4	5	6

UNIT 1	UNIT 2	UNIT 3	UNIT 4	UNIT 5
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____

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33. When these disagreements or disputes occurred, *how often were they handled* in *each* of the following ways during the past six months?

a. By ignoring or avoiding the issues?

b. By smoothing over the issues?

c. By bringing the issues out in the open and working them out among the parties involved?

d. By having a higher level manager or authority resolve the issues between the parties involved?

ALMOST NEVER	SELDOM	ABOUT HALF THE TIME	OFTEN	ALMOST ALWAYS
1	2	3	4	5

34. How well are any differences worked out at this time between your unit and this other unit?

VERY POORLY	POORLY	ADEQUATELY	QUITE WELL	VERY WELL
1	2	3	4	5

	UNIT 1	UNIT 2	UNIT 3	UNIT 4	UNIT 5
33. a.	___	___	___	___	___
b.	___	___	___	___	___
c.	___	___	___	___	___
d.	___	___	___	___	___
34.	___	___	___	___	___

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TO CONCLUDE THIS SECTION, PLEASE ANSWER THE FOLLOWING QUESTIONS USING THE SCALE FOLLOWING QUESTION 41.

	UNIT 1	UNIT 2	UNIT 3	UNIT 4	UNIT 5
35. To what extent has *this unit* carried out its responsibilities and commitments in regard to your unit during the past six months?	___	___	___	___	___
36. To what extent has *your unit* carried out your responsibilities and commitments in regard to this other unit during the past six months?	___	___	___	___	___
37. To what extent do you feel the *relationship* between your unit and this other unit is *productive*?	___	___	___	___	___
38. To what extent is the *time and effort spent* in developing and maintaining the relationship with this other unit *worthwhile*?	___	___	___	___	___
39. Overall, to what extent were you *satisfied with the relationship* between your unit and this other unit during the past six months?	___	___	___	___	___
40. During the past six months, to what extent has *your unit changed or influenced* the services or operations of *this other unit*?	___	___	___	___	___
41. During the past six months, to what extent has *this other unit changed or influenced* the services or operations of *your unit*?	___	___	___	___	___

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSIDERABLE EXTENT	GREAT EXTENT
1	2	3	4	5

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PART ONE

THE NATURE OF YOUR WORK AND JOB

WE WOULD LIKE TO KNOW THE SPECIFIC KINDS of tasks and work activities that make up your job. Please describe below the types of tasks or work activities you have been performing regularly during the past three months. Briefly explain what each task is and indicate the numbers of hours each week you spend doing it.

Task 1: ______ hours/week

Task 2: ______ hours/week

Task 3: ______ hours/week

Task 4: ______ hours/week

Task 5: _____ **hours/week**

Task 6: _____ **hours/week**

Task 7: _____ **hours/week**

Task 8: _____ **hours/week**

1. Indicate the total number of hours per week you normally worked. Hours/week during the past three months: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY THINKING ONLY ABOUT THE TYPES OF TASKS THAT OCCUPY MOST OF YOUR WORKING TIME.

2. *To what extent* do you perform the *same tasks* from day to day? (Circle a number below the scale.)

ALMOST ALL MY TASKS ARE THE SAME DAY-TO-DAY	MANY OF MY TASKS ARE THE SAME DAY-TO-DAY	ABOUT HALF MY TASKS ARE THE SAME DAY-TO-DAY	SOME OF MY TASKS ARE THE SAME DAY-TO-DAY	ALMOST NO TASKS ARE THE SAME DAY-TO-DAY
1	2	3	4	5

3. *How much the same* are the day-to-day situations, problems, or issues you encounter in performing your major tasks? (Circle a number below.)

VERY MUCH THE SAME	MOSTLY THE SAME	QUITE A BIT DIFFERENT	VERY MUCH DIFFERENT	COMPLETELY DIFFERENT
1	2	3	4	5

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4. *How easy* is it for you to *know* whether you do your work correctly?

VERY DIFFICULT	QUITE DIFFICULT	SOMEWHAT EASY	QUITE EASY	VERY EASY
1	2	3	4	5

5. *What percent of the time* are you *generally sure* of what the *outcomes* of your work efforts will be?

40% OR LESS	41–60%	61–75%	76–90%	91% OR MORE
1	2	3	4	5

6. During a normal week, *how frequently* do *exceptions arise* in your work which require *substantially different* methods or procedures for doing it?

VERY RARELY	OCCASIONALLY	QUITE OFTEN	VERY OFTEN	CONSTANTLY
1	2	3	4	5

7. In the past 3 months, *how often* did *difficult problems arise* in your work for which there were no immediate or apparent solutions?

ONCE A WEEK OR LESS	ABOUT 2–4 TIMES A WEEK	ABOUT ONCE A DAY	ABOUT 2–4 TIMES A DAY	5 TIMES OR MORE A DAY
1	2	3	4	5

8. About *how much time* did you spend solving these *work problems*?

LESS THAN 1 HOUR/WEEK	ABOUT 1–4 HOURS/WEEK	ABOUT 1 HOUR/DAY	ABOUT 2–3 HOURS/DAY	4 HOURS OR MORE PER DAY
1	2	3	4	5

9. To what extent does *just your work alone* give you many *clues* to figure out *how well you are doing* your job (without relying on feedback from your supervisor or co-workers)?

MY WORK GIVES ME NO CLUES ON HOW WELL I DO MY JOB	MY WORK GIVES A FEW CLUES ON MY JOB PERFORMANCE	MY WORK GIVES SOME CLUES ON MY JOB PERFORMANCE	MY WORK GIVES MANY CLUES ON MY JOB PERFORMANCE	MY WORK GIVES ALL CLUES NEEDED TO KNOW HOW WELL I DO MY JOB
1	2	3	4	5

10. During the past 3 months, *how often* did you receive *suggestions or feedback* from your *co-workers* on your work?

NOT ONCE	ABOUT ONCE A MONTH	ABOUT ONCE A WEEK	ABOUT EVERY DAY OR SO	SEVERAL TIMES A DAY
1	2	3	4	5

11. *How many hours per week on or off the job* do you spend in some kind of *reading or training* to keep current in the skills needed to do your job?

LESS THAN 1 HR/WK	ABOUT 1–3 HR/WK	ABOUT 4–6 HR/WK	ABOUT 7–9 HR/WK	ABOUT 10 HR/WK OR MORE
1	2	3	4	5

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12. Describe the specific kinds of training programs or reading materials you spent this time on to remain current in your job.

13. When you *began* this job, *how long a period of orientation and training* did you receive that was *directly related to your tasks* in this job?

A FEW HOURS OR LESS	ABOUT A DAY	ABOUT A WEEK	ABOUT A MONTH	MORE THAN A MONTH
1	2	3	4	5

14. How many *years* of academic, vocational, or professional *education* have you obtained *beyond high school*?

YEARS AFTER HIGH SCHOOL									
0	1	2	3	4	5	6	7	8	9

15. What is the highest educational degree you obtained in school?

GRADE SCHOOL DIPLOMA	HIGH SCHOOL DIPLOMA	VOCATIONAL OR CRAFT CERTIFICATION	COLLEGE BACHELOR'S DEGREE	MASTER'S DEGREE	DOCTORAL DEGREE
1	2	3	4	5	6

16. Indicate the *specific major* or *field of specialization* in which you obtained this degree.

17. *How often* do you follow about the *same work methods or steps* for *doing* your major tasks from day to day?

VERY SELDOM	SOMETIMES	ABOUT HALF THE TIME	QUITE OFTEN	VERY OFTEN
1	2	3	4	5

18. To what *extent* did you follow *standard operating procedures* or practices to do your major tasks the past 3 months?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	GREAT EXTENT	VERY GREAT EXTENT
1	2	3	4	5

19. *How many written rules and procedures exist* for doing your major tasks?

VERY FEW IF ANY	A SMALL NUMBER	A MODERATE NUMBER	A LARGE NUMBER	A GREAT NUMBER
1	2	3	4	5

20. *How precisely* do these rules and procedures *specify* how your major tasks are to be done?

VERY GENERAL	MOSTLY GENERAL	SOMEWHAT SPECIFIC	QUITE SPECIFIC	VERY SPECIFIC
1	2	3	4	5

21. *How heavy* was your *work load* during the past 3 months?

OFTEN NOT ENOUGH TO KEEP ME BUSY	SOMETIMES NOT ENOUGH TO KEEP ME BUSY	JUST ABOUT THE RIGHT AMOUNT	HARD TO KEEP UP WITH	ENTIRELY TOO MUCH FOR ME TO HANDLE
1	2	3	4	5

22. *How far in advance* do you generally *know* how much work will be required of you?

ABOUT AN HOUR OR LESS IN ADVANCE	ABOUT A DAY IN ADVANCE	ABOUT A WEEK IN ADVANCE	ABOUT A MONTH IN ADVANCE	ABOUT 6 MONTHS OR MORE IN ADVANCE
1	2	3	4	5

23. During the past 3 months, how much *control* did you have in setting the *pace* of your work?

NONE	VERY LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

24. When considering the various situations that arise in performing your work, what *percent of the time* do you *have* written or unwritten procedures for dealing with them?

0–20%	21–40%	41–60%	61–80%	81–100%
1	2	3	4	5

25. Listed below are four common decisions about your work. *How much authority* do you have in making each of the following decisions about your work:

	AMOUNT OF AUTHORITY I HAVE IN EACH DECISION				
	NONE	LITTLE	SOME	QUITE A BIT	VERY MUCH
a. Determining *what* tasks I will perform from day to day?	1	2	3	4	5
b. *Setting quotas* on how much work I have to complete?	1	2	3	4	5
c. *Establishing rules and procedures* about *how* my work is to be done?	1	2	3	4	5
d. Determining *how work exceptions* are to be handled?	1	2	3	4	5

26. How *much* does your *supervisor hold you personally accountable* for the *work decisions* you make in your job?

NOT AT ALL	VERY LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

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27. *How clearly* do you *know what level of work performance* is *expected* from you (in terms of amount, quality, and timeliness of output)?

VERY UNCLEAR	QUITE UNCLEAR	SOMEWHAT CLEAR	QUITE CLEAR	VERY CLEAR
1	2	3	4	5

28. How *clearly* does your *job description specify* the *standards of performance* on which your job is evaluated?

THERE IS NO JOB DESCRIPTION FOR MY JOB.	MY JOB DESCRIPTION DOES NOT STATE ANY PERFORMANCE STANDARDS TO BE ACHIEVED IN THIS JOB.	MY JOB DESCRIPTION IS VERY GENERAL IN STATING WHAT PERFORMANCE STANDARDS ARE TO BE ACHIEVED.	MY JOB DESCRIPTION IS QUITE CLEAR IN STATING WHAT PERFORMANCE STANDARDS ARE TO BE ACHIEVED.	MY JOB DESCRIPTION IS VERY CLEAR AND PRECISE IN STATING WHAT PERFORMANCE STANDARDS ARE TO BE ACHIEVED.
1	2	3	4	5

29. To what degree has your *supervisor discussed* with *you* these *performance standards* on which your job is evaluated?

MY SUPERVISOR NEVER DISCUSSED THEM WITH ME.	MY SUPERVISOR ONLY MENTIONED THEM TO ME VERY GENERALLY AND DID NOT CLARIFY THEM.	MY SUPERVISOR DISCUSSED THEM WITH ME QUITE SPECIFICALLY AND CLEARLY.	MY SUPERVISOR DISCUSSED THEM WITH ME IN A VERY DETAILED AND CLEAR WAY.
1	2	3	4

30. *How hard* is it to *attain* the *level of performance* that is *expected* from you?

I DON'T KNOW WHAT'S EXPECTED OF ME.	QUITE EASY	QUITE HARD	VERY HARD BUT ATTAINABLE	EXCESSIVELY HARD AND IMPOSSIBLE TO ATTAIN
1	2	3	4	5

31. To what extent do *you believe* that the *performance standards* upon which your work is evaluated are *fair*?

I DON'T KNOW WHAT STANDARDS ARE USED TO EVALUATE MY WORK.	VERY UNFAIR	SOMEWHAT FAIR	QUITE FAIR	VERY FAIR
1	2	3	4	5

32. *How much* does your *supervisor hold you personally responsible* for achieving these *performance standards* for your job?

NOT AT ALL	VERY LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

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33. During the *past year, how often did* your immediate *supervisor discuss* your *work performance with you?*

NOT ONCE	ABOUT 1–4 TIMES A YEAR	ABOUT ONCE A MONTH	ABOUT ONCE A WEEK	ABOUT EVERY DAY OR SO
1	2	3	4	5

34. When your work performance was discussed with you, how often did you receive *practical suggestions* for improving your work?

NEVER	SELDOM	ABOUT HALF THE TIME	OFTEN	EVERY TIME
1	2	3	4	5

35. *If you attain the performance level* that is expected of you, *how likely is it that* each of the following *will happen*:	NO CHANCE	SMALL CHANCE	50% CHANCE	QUITE LIKELY	ALMOST A CERTAINTY
a. You will be *recognized* for your good work (e.g., given a special word of appreciation or given a pat-on-the-back)?	1	2	3	4	5
b. You will be given a *promotion* in this organization?	1	2	3	4	5

36. *If you do not attain the performance level* that is expected of you, *how likely is it that each* of the following *will happen*:	NO CHANCE	SMALL CHANCE	50% CHANCE	QUITE LIKELY	ALMOST A CERTAINTY
a. You will be reprimanded, or told to improve your work?	1	2	3	4	5
b. You will be demoted in this organization?	1	2	3	4	5

YOUR FEELINGS ABOUT YOUR JOB

NOW WE WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT HOW YOU PERSONALLY FEEL ABOUT YOUR JOB.

37. *How satisfied* are you with each of the following:	VERY UNSATISFIED	QUITE UNSATISFIED	SOMEWHAT SATISFIED	QUITE SATISFIED	VERY SATISFIED
a. Your job?	1	2	3	4	5
b. Your supervisor?	1	2	3	4	5
c. Your pay?	1	2	3	4	5

	VERY UNSAT-ISFIED	QUITE UNSAT-ISFIED	SOME-WHAT SATIS-FIED	QUITE SATIS-FIED	VERY SATIS-FIED
d. The friendliness and cooperativeness of your *co-workers*?	1	2	3	4	5
e. The *career progress* you have made in this organization up to now?	1	2	3	4	5
f. Your chances for *career advancement* in this organization *in the future*?	1	2	3	4	5

	NONE	A LITTLE	SOME	QUITE A BIT	VERY MUCH
38. *How much effort* do you put into your work?	1	2	3	4	5
39. *How much* did you try *to improve* your job performance in the past 3 months?	1	2	3	4	5

40. Each of the statements below is something that a person might say about his or her job. Please indicate your own, personal *feelings* about your job by circling a number on the scale to the right of each statement to indicate how much you agree or disagree with each statement.

	DISAGREE STRONGLY	DISAGREE SOMEWHAT	NEUTRAL	AGREE-SOME-WHAT	AGREE STRONGLY
a. It's hard, on this job, for me to care very much about whether or not the work gets done right.	1	2	3	4	5
b. My opinion of myself goes up when I do this job well.	1	2	3	4	5
c. My supervisor often lets me know how well I am performing my job.	1	2	3	4	5
d. I feel a great sense of personal accomplishment when I do this job well.	1	2	3	4	5
e. I feel a very high degree of *personal responsibility for the work I do on this job.*	1	2	3	4	5
f. I frequently think of quitting this job.	1	2	3	4	5

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	DISAGREE STRONGLY	DISAGREE SOMEWHAT	NEUTRAL	AGREE-SOME-WHAT	AGREE STRONGLY
g. I feel bad and unhappy when I discover that I have performed poorly on this job.	1	2	3	4	5
h. My co-workers on this job almost *never* give me any "feedback" about how well I am doing on my work.	1	2	3	4	5
i. I feel I should personally take the credit or blame for the results of my work on this job.	1	2	3	4	5
j. My own feelings generally are *not* affected much one way or the other by how well I do on this job.	1	2	3	4	5
k. I am recognized and rewarded for putting in additional effort to do superior work in this job.	1	2	3	4	5
l. I am reprimanded or told to "shape up" when I do inferior work in this job.	1	2	3	4	5

	HOW OFTEN RECEIVED OR SENT WRITTEN REPORTS OR MEMOS IN PAST 3 MONTHS				
73. During the past 3 months, *how often* did you receive or send *written reports* or *memos* related to your work from or to each of the following people:	NOT ONCE	ABOUT 1–3 TIMES A MONTH	ABOUT 1–3 TIMES A WEEK	ABOUT 1–3 TIMES A DAY	ABOUT EVERY HOUR
a. Your unit supervisor?	1	2	3	4	5
c. People outside of your unit?	1	2	3	4	5

	HOW OFTEN HAD WORK DISCUSSIONS IN PAST 3 MONTHS				
74. During the past 3 months *how often* did you have work-related *discussions* (*face-to-face or by telephone*) with each of the following people:	NOT ONCE	ABOUT 1–3 TIMES A MONTH	ABOUT 1–3 TIMES A WEEK	ABOUT 1–3 TIMES A DAY	ABOUT EVERY HOUR
a. Your unit supervisor?	1	2	3	4	5
c. People outside of your unit?	1	2	3	4	5

	HOW OFTEN WERE MEETINGS HELD IN PAST THREE MONTHS					
75. During the past 3 months, *how often* were you involved in *special group problem-solving meetings* with:	NOT ONCE	ABOUT ONCE A MONTH	ABOUT EVERY 2 WEEKS	ABOUT ONCE A WEEK	ABOUT 2–4 TIMES A WEEK	ONCE A DAY OR MORE
a. people from your unit?	1	2	3	4	5	6
76. *How often* were regularly scheduled staff meetings held among people in your unit?	1	2	3	4	5	6

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77. During the past 3 months how *often* did *disagreements or arguments* occur:	HOW OFTEN DISAGREEMENTS OR ARGUMENTS OCCURRED					
	NOT ONCE	ABOUT ONCE A MONTH	ABOUT EVERY 2 WEEKS	ABOUT ONCE A WEEK	SEVERAL TIMES A WEEK	EVERY DAY
a. Between unit members and your supervisor?	1	2	3	4	5	6
c. Between people in your unit and people outside of your unit?	1	2	3	4	5	6

78. In general, when these disagreements or arguments occurred, *how often were they handled* in *each* of the following ways during the past three months:	HOW OFTEN DISPUTES RESOLVED THIS WAY				
	ALMOST NEVER	SELDOM	ABOUT HALF THE TIME	OFTEN	VERY OFTEN
a. By ignoring or avoiding the issues?	1	2	3	4	5
b. By smoothing over the issues?	1	2	3	4	5
c. By bringing the issues out in the open and working them out among the people involved?	1	2	3	4	5
d. By having a higher-level supervisor resolve the issues between the people involved?	1	2	3	4	5

79. Overall, to what *extent* did this *conflict resolution help or hinder* your unit's performance?

HINDERS PERFORMANCE A LOT	HINDERS MORE THAN HELPS	NEITHER HELPS NOR HINDERS	HELPS MORE THAN HINDERS	HELPS PERFORMANCE A LOT
1	2	3	4	5

80. *How much* are unit *members willing to give other members the support* they need to do a good job?

NONE	LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

A SELF-APPRAISAL OF YOUR UNIT

NOW MAKE A SELF-ASSESSMENT OF THE ORGANIZATION AND EFFECTIVENESS OF YOUR UNIT. HOPEFULLY, THE QUESTIONS YOU HAVE ANSWERED SO FAR STIMULATED YOU TO MAKE SUCH A SELF-ASSESSMENT.

A. Describe the major *strengths* of your work unit.

B. Describe the major *weaknesses* of your work unit.

C. Describe the *specific organizational changes* you think are necessary to *improve* the effectiveness of your unit.

FINALLY, PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOURSELF. YOUR ANSWERS ARE USEFUL FOR STATISTICAL ANALYSIS AND ARE STRICTLY CONFIDENTIAL.

82. *How long* have you *worked in this organization*?

LESS THAN 6 MONTHS	6 MONTHS-2 YEARS	3-5 YEARS	6-10 YEARS	MORE THAN 10 YEARS
1	2	3	4	5

83. List below the *positions* or *job titles* you have held since your began working for this organization.

Indicate the *months* and *years* during which you held each position.

1. ________________ From ____ to ____
2. ________________ From ____ to ____
3. ________________ From ____ to ____
4. ________________ From ____ to ____
5. ________________ From ____ to ____
6. ________________ From ____ to ____

84. List below the *positions or job titles* you have held *before* you began working for this organization (if any).

1. ________________ From ____ to ____
2. ________________ From ____ to ____
3. ________________ From ____ to ____
4. ________________ From ____ to ____
5. ________________ From ____ to ____
6. ________________ From ____ to ____

86. Indicate your sex: Female ____ (1) Male ____ (2)

87. How old were you on your last birthday? ____ Years old.

88. How many dependents do you have? (You and others who depend on your income for their financial support.) ____ Number of dependents.

(HOURS)

rker ______________________________

Day's Date ______________________

Week Ending ______________________

CLIENT-RELATED SERVICE

IENT	I.D.NO.	SCREENING/ REFERRAL	CLIENT INTERVIEW/ HOME VISIT	TELEPHONE/ CLIENT	AGENCY CONTACT	SUPERVISION/ CONSULTATION	CASE CONFERENCE	CASE RECORDING/ CORRESPONDENCE	ASSESSMENT/ REASSESSMENT	TRAVEL	OTHER	HOURS	MINUTES
										TOTAL		

NON CLIENT-RELATED SERVICES	Hrs.	M
OUTREACH/CASEFINDING		
TRAINING/EDUCATION		
PROVIDING		
RECEIVING		
AGENCY RELATIONS		
STAFF MEETINGS		
PROJECT ADMINISTRATION		
TRAVEL		
OTHER		
TOTAL NON-CLIENT		
TOTAL CLIENT		
GRAND TOTAL		

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EXHIBIT 7

In a previous survey, the Elder Abuse Project reported that they coordinated in some way with your organizational unit during the past six months. We would like your perspective on the relationship your agency has with the Elder Abuse Project. The content of this questionnaire is completely confidential.

Your answers will be grouped with those of other people, and no individual's responses will ever be identified in any report. If you would like one, a copy of our final report will be sent to you.

INTRODUCTORY QUESTIONS

The following questions are very important for properly coding and analyzing the data. In addition, they are needed to make sure we have your correct address so that we can mail you a report on the results of this study. As noted before, all responses are kept strictly confidential.

1. Write YOUR NAME: ______________________________
2. Your ADDRESS: ______________________________

   ____
3. Name of ORGANIZATION in which you work: ______________
4. Name of OFFICE or DIVISION in which you work: ______________
5. Name of UNIT in which you work: ______________
6. Write your present JOB TITLE or POSITION: ______________
7. How many years and months have you held this position?

   ________Years, ________Months.
8. How many years and months have you worked in your organization?

   ________Years, ________Months.

INSTRUCTIONS: Please answer the following questions by circling the appropriate numbers on the answer scale that follows each question. If a question does not seem applicable to you or your agency, leave it blank.

1. How well are you personally acquainted with the staff of the Elder Abuse Project?

NO PERSONAL ACQUAINTANCE	NOT VERY WELL	SOMEWHAT WELL	QUITE WELL	VERY WELL
1	2	3	4	5

2. How much do you and the staff of the Elder Abuse Project agree on:

   a. The goal priorities of your agency?

DON'T KNOW	DISAGREE MUCH	AGREE A LITTLE	AGREE SOMEWHAT	AGREE QUITE A BIT	AGREE VERY MUCH
0	1	2	3	4	5

   b. The specific ways work is done or services provided by your agency?

DON'T KNOW	DISAGREE MUCH	AGREE A LITTLE	AGREE SOMEWHAT	AGREE QUITE A BIT	AGREE VERY MUCH
0	1	2	3	4	5

   c. The specific terms of the relationship between your agency and the Elder Abuse Project?

DON'T KNOW	DISAGREE MUCH	AGREE A LITTLE	AGREE SOMEWHAT	AGREE QUITE A BIT	AGREE VERY MUCH
0	1	2	3	4	5

3. How well-informed are you about the specific goals and services of the Elder Abuse Project?

NOT AT ALL	LITTLE INFORMED	SOMEWHAT INFORMED	QUITE INFORMED	VERY WELL INFORMED
1	2	3	4	5

4. Prior to the past six months, to what extent has your agency had effective working relationships with the Elder Abuse Project?

NO PRIOR CONTACT	TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSID-ERABLE EXTENT	GREAT EXTENT
0	1	2	3	4	5

5. During the past six months, how much was your agency involved with the Elder Abuse Project for each of the following reasons:

a. To receive or send clients?

NOT AT ALL	A LITTLE	SOME-WHAT	QUITE A BIT	VERY MUCH
1	2	3	4	5

b. To receive or send resources (money, personnel, equipment, office space)?

NOT AT ALL	A LITTLE	SOME-WHAT	QUITE A BIT	VERY MUCH
1	2	3	4	5

c. To receive or send technical assistance (e.g. consulting or staff services)?

NOT AT ALL	A LITTLE	SOME-WHAT	QUITE A BIT	VERY MUCH
1	2	3	4	5

d. To receive or send information for purposes of coordination, control, planning, or evaluation?

NOT AT ALL	A LITTLE	SOME-WHAT	QUITE A BIT	VERY MUCH
1	2	3	4	5

6. Consider now the equality of the give-and-take relationship with the Elder Abuse Project compared to other agencies that you are involved with. How fair do you feel are the payoffs to your agency from the Elder Abuse Project?

WE GET MUCH LESS THAN WE OUGHT	WE GET SOMEWHAT LESS THAN WE OUGHT	BALANCED	WE GET SOMEWHAT MORE THAN WE OUGHT	WE GET MUCH MORE THAN WE OUGHT
1	2	3	4	5

7. For the Elder Abuse Project to accomplish its goals and responsibilities, how much does it need the services, resources, or support from your agency?

NOT AT ALL	VERY LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

8. For your agency to accomplish its goals and responsibilities, how much do you need the services, resources, or support from the Elder Abuse Project?

NOT AT ALL	VERY LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

9. How much say or influence does the Elder Abuse Project have on the internal operations of your agency in the area of elder abuse?

NONE	LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

10. How much say or influence does your agency have on the internal operations of the Elder Abuse Project?

NONE	LITTLE	SOME	QUITE A BIT	VERY MUCH
1	2	3	4	5

11. To what extent have the terms of the relationship between your agency and the Elder Abuse Project:

    a. Been explicitly verbalized or discussed?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSIDERABLE EXTENT	GREAT EXTENT
1	2	3	4	5

    b. Been written down in detail?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSIDERABLE EXTENT	GREAT EXTENT
1	2	3	4	5

12. During the past six months, what percent of your total working hours did you spend on matters directly related to the operations, work, or activities of the Elder Abuse Project?

Indicate percent ________%

13. During the past six months, how frequently have people in your agency communicated or been in contact with people in the Elder Abuse Project?

NOT ONCE	1-2 TIMES	ABOUT MONTHLY	ABOUT EVERY 2 WEEKS	ABOUT WEEKLY	ABOUT DAILY	MANY TIMES DAILY
0	1	2	3	4	5	6

14. When you want to communicate with individuals in the Elder Abuse Project, how much difficulty have you had getting in touch with them?

NO CONTACT	NONE	LITTLE	SOME	QUITE A BIT	VERY MUCH
0	1	2	3	4	5

15. Overall, how much difficulty do you experience in getting ideas clearly across to individuals in the Elder Abuse Project when you communicate with them?

NO CONTACT	NONE	LITTLE	SOME	QUITE A BIT	VERY MUCH
0	1	2	3	4	5

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16. During the last six months, how often were there disagreements or disputes between people in your agency and the Elder Abuse Project?

NOT ONCE	ABOUT ONCE A MONTH	ABOUT EVERY 2 WEEKS	ABOUT ONCE A WEEK	SEVERAL TIMES A WEEK	EVERY DAY
1	2	3	4	5	6

17. To what extent did individuals in the Elder Abuse Project hinder your agency in performing its functions during the past six months?

DON'T KNOW	TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSIDERABLE EXTENT	GREAT EXTENT
0	1	2	3	4	5

18. How well are any differences worked out at this time between your agency and the Elder Abuse Project?

VERY POORLY	POORLY	ADEQUATELY	QUITE WELL	VERY WELL
1	2	3	4	5

19. Overall, how important was the Elder Abuse Project in attaining the goals of your agency during the past six months?

NOT VERY IMPORTANT	SOMEWHAT IMPORTANT	QUITE IMPORTANT	VERY IMPORTANT	ABSOLUTELY CRUCIAL
1	2	3	4	5

20. To what extent has the Elder Abuse Project carried out its responsibilities and commitments in regard to your agency during the past six months?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSIDERABLE EXTENT	GREAT EXTENT
1	2	3	4	5

21. To what extent has your agency carried out your responsibilities and commitments in regard to the Elder Abuse Project during the past six months?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSIDERABLE EXTENT	GREAT EXTENT
1	2	3	[illegible]	5

22. To what extent do you feel the relationship between your agency and the Elder Abuse Project is productive?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSID-ERABLE EXTENT	GREAT EXTENT
1	2	3	4	5

23. To what extent is the time and effort spent in developing and maintaining the relationship with the Elder Abuse Project worthwhile?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSID-ERABLE EXTENT	GREAT EXTENT
1	2	3	4	5

24. Overall, to what extent are you satisfied with the relationship between your agency and the Elder Abuse Project during the past six months?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSID-ERABLE EXTENT	GREAT EXTENT
1	2	3	4	5

25. During the past six months, to what extent has your agency changed or influenced the services or operations of the Elder Abuse Project?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSID-ERABLE EXTENT	GREAT EXTENT
1	2	3	4	5

26. During the past six months, to what extent has the Elder Abuse Project changed or influenced the services or operations of your unit?

TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	CONSID-ERABLE EXTENT	GREAT EXTENT
1	2	3	4	5

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27. Describe the major strengths of the Elder Abuse Project.

28. Describe the major weaknesses of the Elder Abuse Project.

29. Describe any specific changes you think are necessary to improve the Elder Abuse Project.

EXHIBIT 8

ELDER ABUSE/NEGLECT SURVEY

I. Agency Name: ____________________

Job Title: ____________________

NOTE:

This survey is concerned with persons 60 years and over living in the community, who are victims of abuse/neglect (i.e., abuse/neglect by relatives, neighbors, or caretakers in private residences, not professional or institutional or self-abuse). Abuse and neglect are defined below:

ABUSE:

Physical -	the infliction of physical pain or injury, physical coercion (confinement against one's will) e.g., slapped, bruised, sexually molested, cut, burned, physically restrained, etc.
Psychological -	the infliction of mental anguish, e.g., called names, treated as a child, frightened, humiliated, intimidated, threatened, isolated, etc.
material -	the illegal or improper exploitation and/or use of funds or other resources

NEGLECT:

active -	refusal or failure to fulfill a caretaking obligation, INCLUDING a conscious and intentional attempt to inflict physical or emotional distress on the elder e.g., deliberate abandonment or deliberate denial of food or health-related services
passive -	refusal or failure to fulfill a caretaking obligation, EXCLUDING a conscious and intentional attempt to inflict physical or emotional distress on the elder e.g., abandonment, denial of food, or health-related services because of inadequate knowledge, laziness, infirmity or disputing the value of prescribed services.

II-a. Please check one of the following:

(1) ___ The agency/organization staff is aware of elder abuse/neglect but has not encountered specific cases.

(2) ___ The agency/organization staff has known at least one case of elder abuse/neglect.

(3) ___ The agency/organization staff is not aware of elder abuse/neglect.

II-b. If you checked (1) above, name the agencies that you would think of turning to with cases of elder abuse/neglect.

If you checked (2) above, name the agencies you have turned to in the past for help.

III. If you have been involved in elder abuse/neglect cases, list any services which you think are needed to help individuals but which are presently unavailable.

IV-a. Does you agency have a specific procedure for dealing with suspected cases of elder abuse/neglect?

_____ yes

_____ no

IV-b. If you answered YES above, please indicate whether your agency has documented guidelines or a written policy for dealing with cases.

_____ yes

_____ no

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If you answered NO to IV-b, please describe the way you would handle a suspected elder abuse/neglect case?

V-a. Are you aware that there is a specific service project in your area administered by Elder Home Care Services of Worcester for dealing with elder abuse/neglect?

_____ yes

_____ no

V-b. If you answered YES to V-a above, please indicate whether you have referred a client to your area's elder abuse/neglect Project.

_____ yes

_____ no

V-c. If you answered YES to V-b above, please rate the response you received from the elder abuse/neglect Project.

_____ Excellent

_____ Good

_____ Fair

_____ Poor

V-d. If you answered YES to V-a above, please provide details about the response you received from the Project:

VI. If your agency has been involved in cases of elder abuse/neglect, indicate the degree of satisfaction with the extent of cooperation or coordination of services provided in your area.

_____ very satisfied

_____ reasonably satisfied

_____ not at all satisfied

VII. Using the definitions and categories outlined on page 1 of the questionnaire, please specify the number of cases (definite or highly suspicious) of domestic elder abuse/neglect (i.e. abuse/neglect by relative, neighbors, or caretakers in private residences, not professional or institutional or self-abuse) which were referred to your agency or department and with which you have been involved during the time period: October 1, 1982-March 31, 1983 (include cases that were first reported prior to October 1, 1982 if you were still actively involved with them during the above time period).

NOTE: Many cases of elder abuse/neglect have multiple manifestations e.g. both physical and psychological symptoms. If a particular case has both physical and psychological signs or financial and physical manifestations, for example, please check all the appropriate categories below. Then as a summary, under "total number of individuals", indicate the number of discrete cases (individuals).

Number of cases showing evidence of physical abuse _____

Number of cases showing evidence of psychological abuse _____

Number of cases showing evidence of material abuse _____

Number of cases showing evidence of active neglect _____

Number of cases showing evidence of passive neglect _____

TOTAL NUMBER OF INDIVIDUALS SHOWING EVIDENCE OF ABUSE/NEGLECT _____

VIII-a. Did any of the staff of your agency/organization attend a program or presentation on elder abuse/neglect in the last two years?

_____ yes

_____ no

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VIII-b. If you answered YES to VIII-a, please check the type of program/presentation attended, indicate the organizer or sponsor, and check the rating.

TYPE	PROGRAM SPONSOR/ORGANIZER	Excellent	Good	Fair	Poor
Inservice					
Workshop					
Lecture					
Seminar Series					
Course					
Conference					
Other: Specify					

IX. Any additional comments?

THANK YOU FOR YOUR ASSISTANCE

PLEASE RETURN TO:
Rosalie S. Wolf
University Center on Aging
UMass Medical Center
55 Lake Avenue North
Worcester, MA 01605
(Tel. No. 856-3084)

EXHIBIT 9

TRAINING PROGRAM
FOR PROTECTIVE SERVICE WORKERS

Evaluation

1. Please indicate your position:

___ Protective Service Worker
___ Supervisor, Protect Service Worker
___ Staff Member who provides backup (please specify)

____

___ Other (please specify)

____

Type of organization:

___ home care corporation
___ other (please specify)

____

2. Please check your reaction to the following:

	Quality of Material			Delivery of Material			Value of Material			Discussion Time		
Program Content	EXCELLENT	SATISFACTORY	UNSATISFACTORY	EXCELLENT	SATISFACTORY	UNSATISFACTORY	EXCELLENT	SATISFACTORY	UNSATISFACTORY	EXCELLENT	SATISFACTORY	UNSATISFACTORY
Role of the Protective Service Worker												
Identification of the Abused Client												
Group Assignments												
Principles and Dilemmas of Practice												
Special Problems Facing the PS Worker												
Guest Speaker (s)												
The Service Plan												

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3. As a result of the training, do you feel better prepared to handle the following issues?

(please circle one)

	don't know	no				very much better
	0	1	2	3	4	5
Access to Abused/Family	0	1	2	3	4	5
Abuser Receptivity to Services	0	1	2	3	4	5
Abused Receptivity to Services	0	1	2	3	4	5
Problem Identification	0	1	2	3	4	5
Problem Prioritization	0	1	2	3	4	5
Goal Formation	0	1	2	3	4	5
Service Plan	0	1	2	3	4	5
Service Coordination	0	1	2	3	4	5
Worker Role	0	1	2	3	4	5
Worker Responsiblity to Client	0	1	2	3	4	5
Worker Responsiblity to Other Workers	0	1	2	3	4	5
Confidentiality	0	1	2	3	4	5
Worker Liability	0	1	2	3	4	5
Worker Values	0	1	2	3	4	5
Cultural Differences	0	1	2	3	4	5
Alcoholism and the Abuse Problem	0	1	2	3	4	5
Mental Illness and the Abuse Problem	0	1	2	3	4	5
Sexual Abuse	0	1	2	3	4	5
Case Transfer	0	1	2	3	4	5
Case Conference	0	1	2	3	4	5
Team Approach	0	1	2	3	4	5
Case Closing	0	1	2	3	4	5
No Resolution of Problem	0	1	2	3	4	5

4. Overall rating of the Program

	don't know 0	excellent 1	good 2	poor 3	fair 4
Program Instructor	0	1	2	3	4
Guest Instructor	0	1	2	3	4
Guest Speaker (s)	0	1	2	3	4
Style of Presentations	0	1	2	3	4
Use of Time	0	1	2	3	4
Organization	0	1	2	3	4
Physical Facilities	0	1	2	3	4
Food	0	1	2	3	4

5. Are there any areas which you would like to see covered in future programs? Please list:

General Comments:

THANK YOU

EXHIBIT 10

Part II Assessment of Serious Physical or Emotional Abuse and Neglect

A. Evidence of Serious Physical Abuse	PRESENT	SUSPECT	ABSENT	PRES/UNREL	NARRATIVE
1. Bruises, Welts	3	2	1	0	
2. Sprains, Dislocations	3	2	1	0	
3. Burns, Scalding	3	2	1	0	
4. Abrasions, Lacerations	3	2	1	0	
5. Wounds, Cuts, Puncture	3	2	1	0	
6. Internal Injuries	3	2	1	0	
7. Broken Bones	3	2	1	0	
8. Sexual Molestation	3	2	1	0	
9. Other (Specify)	3	2	1	0	

B. Evidence of Serious Emotional Abuse	PRESENT	SUSPECT	ABSENT	PRES/UNREL
1. Sleep Disturbance	3	2	1	0
2. Worried, Anxious	3	2	1	0
3. Irritable, Easily Upset	3	2	1	0
4. Change in Eating Habits	3	2	1	0
5. Loss of Interest	3	2	1	0
6. Fear of Retribution	3	2	1	0
7. Suicidal Talk, Wishes	3	2	1	0
8. Shaking, Trembling and/or Crying Frequently	3	2	1	0
9. Other (Specify)	3	2	1	0

C. Abusive Actions (Emotional and Physical)	REPORTED	ABSENT	NARRATIVE
1. Insulted, swore, or yelled at victim	1	2	
2. Threatened, Coerced	1	2	
3. Confined/Isolated Involuntary	1	2	
4. Threw Objects at Victim	1	2	
5. Pushed, Grabbed or Shoved Victim	1	2	
6. Slapped, Hit or Kicked Victim	1	2	
7. Threatened Victim with a Knife or Gun	1	2	
8. Used Knife or Gun on Victim	1	2	
9. Other (Specify)	1	2	

D. Evidence of Serious Neglect	PRESENT	SUSPECT	ABSENT	PRES/UNREL
1. Dirt, Fleas or Lice on Person	3	2	1	0
2. Skin Rashes	3	2	1	0
3. Sores	3	2	1	0
4. Malnourished	3	2	1	0
5. Dehydrated	3	2	1	0
6. Inappropriate Clothing	3	2	1	0
7. Fecal/Urine Smell	3	2	1	0
8. Untreated Medical Condition	3	2	1	0
9. Other (Specify)	3	2	1	0

E. Neglectful Act[illegible]	REPORTED	ABSENT	NARRATIVE
1. Failure to Provide Adequate Food	1	2	
2. Failure to Provide Adequate Heat	1	2	
3. Failure to Provide Adequate Personal Care	1	2	
4. Failure to Provide Adequate Supervision	1	2	
5. Withholding/Failing to Provide the Following:	1	2	
a. Prescribed Medication	1	2	
b. Medical Equipment or Aids	1	2	
c. Other Prescribed Medical Services	1	2	
6. Failure to Fulfill Other Caretaking Obligations (Specify)	1	2	

F. Financial Exploitation	REPORTED	ABSENT
1. Mismanagement of Victim's Income (Specify)	1	2
2. Misappropriation of Victim's Income (Specify)	1	2
3. Other (Specify)	1	2

G. Physical Environment	PROBLEM	NO PROBLEM	NARRATIVE
1. Repair	1	0	
2. Level of Cleanliness	1	0	
3. Architectural Barriers	1	0	
4. Usual Facilities	1	0	
5. Living Area (Specify)	1	0	
6. Utilities (Specify)	1	0	
7. Fire Safety	1	0	
8. Pest Control	1	0	
9. Other (Specify)	1	0	

H. Victim Dependency on Abuser	NOT AT ALL	SOMEWHAT DEPENDENT	EXTREMELY DEPENDENT
1. Personal Care	0	1	2
2. Finances	0	1	2
3. Companionship	0	1	2
4. Household maintenance (cooking, cleaning, etc.)	0	1	2
5. Transportation	0	1	2

	VICTIM			ABUSER			
	VERIFIED	SUSPECT	ABSENT	VERIFIED	SUSPECT	ABSENT	NARRATIVE
I. Risk Factors							
1. Live Together	2	1	0	2	1	0	
2. Alcohol Abuser	2	1	0	2	1	0	
3. Drug Abuser	2	1	0	2	1	0	
4. Emotional Problems	2	1	0	2	1	0	
5. Previous Psychiatric Hospitalization	2	1	0	2	1	0	
6. Mentally Retarded	2	1	0	2	1	0	
7. Financial Dependency on Other One	2	1	0	2	1	0	
8. Other Dependency	2	1	0	2	1	0	
9. Unemployed	2	1	0	2	1	0	
10. History of Assaults on Others	2	1	0	2	1	0	
11. Unable to Ward Off Attack	2	1	0	2	1	0	
12. Unable to Summon Assistance	2	1	0	2	1	0	
13. Confused and disoriented	2	1	0	2	1	0	
14. Socially Isolated	2	1	0	2	1	0	
15. Unable to Care for Self if Left Alone	2	1	0	2	1	0	

Part III Alleged Abuser

1. Name ______________________________

2. Address ______________________________

____

____

____

3. Telephone # ______________________________

4. Relationship to Client (circle)

   1. Son
   2. Daughter
   3. Husband
   4. Wife
   5. Son-in-Law
   6. Daughter-in-Law
   7. Other Relative
      (Specify relationship)

      ____

   8. Non-relative (Specify friend, neighbor, etc.)

      ____

5. Year of Birth ______________________________

6. Marital Status

   1. Single (Never Married)
   2. Married
   3. Divorced
   4. Widowed
   5. Separated

NARRATIVE

Part IV Assessment of Need for Protective Intervention

1. Summary of Assessment

2. Statement of Reasonable Cause

3. Signatures

Protective Service Worker ______________________ Date ________

Supervisor ______________________ Date ________

Part V Key Contacts

A. Other Agencies Involved

Agency Name	Telephone	Contact Person	Agency Verified Abuse?		Agency Reported Abuse?		Current Agency Invol ment (Amount of cont Services Delivered,
1.			yes	no	yes	no	
2.							
3.							
4.							
5.							

B. Family (exclude alleged abuser), Friends, Neighbors, Others

Name and Address	Telephone	Relationship	Frequency of Contact	Assessments of Willingness to Help
1.				
2.				
3.				
4.				
5.				
6.				

Part VI Actions Taken

A. Case opened by designated agency for protective services 1.....Yes 2.....No

B. Case opened for case management service by home care corporation 1...Yes 2...No

C. Case referred to other agencies 1.....Yes 2.....No

Explain reason for referral ______________________________

____

____

Name of Agency ______________________________ Date ______________

Name of Agency ______________________________ Date ______________

Name of Agency ______________________________ Date ______________

EXHIBIT 11

Client Code ______________

(1) Casemanager's Cost (   )= $7.18/hr. x ______ = ________

(2) Project Director's cost to case= $2.19/client/mo. = 2.19

(3) Indirect Human Resources Costs:

(A) Supervisor's costs to client= $4.36
(B) Administrator's costs to client = 0.00
(C) Secretarial costs to client = 4.83
(D) Accounting staff costs/client= 1.16
Subtotal = $10.35

10.35

(4) Services:

(A) Homemaker ______/hr. x ________ hrs./mo.= ________
(B) Chores 6.95/hr. x ________ hrs./mo.= ________
(C) Cab Rides 3.62/rd. x ________ rides " = ________
(D) Meals 2.66/ml. x ________ meals " = ________
(E) Misc. = ________

Subtotal = ________

____

(5) Overhead:

(A) Space/client= $3.33/client/mo.
(B) Communication/client= 1.67/ " / "
(C) Travel= ______ miles x .20¢= ________
(D) Supplies/client= 1.39/client/mo.
(E) Printing/ client= 1.11/client/mo.
(F) Postage/client= .83/ " / "
(G) Audit/client= .42/ " / "
(H) Maintenance/client= .56/ " / "

Subtotal= ____________

____

(6) Workers Benefit Program (see explanation sheet)= 9.69

TOTAL= ________

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Explanation of Calculations

The model was drawn up in such a way to encompass all the inputs possible into any case in the abuse project. Thus, supervisory staff, accounting staff, services, travel, and overhead were all included in the calculations. Figures taken by which to proportion were taken from the 1982 budget. Each client was apportioned the exact amount of all overhead costs (excluding travel, for which each case was studied as to its' needs separately). All hour calculations were documented over the time period specified (1 four-week month). All calculations are documented below, any further explanation will accompany the calculations.

Case Manager

Weekly salary=269.23 divided by 37.5hr. week= $7.18hr.

Amount of time spent over the course of the month was documented and tabulated and then multiplied by the hourly wage.

Project Director's costs

Weekly salary= $307.69, one-half of which is paid by the projects funds=$153.85week. This is then divided by 37.5hr. week= $4.11hr.

Tabulated time for direct supervision to on her cases was documented as 16 hours for the month.

16hrs. x $4.11/hr.=$65.76 divided by 30 clients= $2.19/client/mo.

Indirect Human Resources costs

A. **Supervisor** = wage=10.91hr. x 12hrs./mo. spent with project
= $130.92 divided by 30 clients= $4.36/client/mo.

B. **Administrator** spends no time with the project whatsoever= $0.

C. Secretarial costs= 4-days/month, clerk salary= 181.17wk.divided by 37.5 hour week= $4.83hr. x 30 hours a month=$144.90 divided by 30 clients- 4.83/client/mo.

D. Accounting staff costs= total salaries of $556.43 divided by 1,950 clients in Elder Home Care = $.29¢/week x 4-weeks= $1.16/client/

Services: Costs were taken as the going rate at the prevailing time or the February average costs. Some homemakers receive special pay as geriatric aids, this is reflected in the higher costs in some of the homemaker catagories.

Calculations: Continued

Overhead: All averages were taken based on a 30 client caseload. Travel was based on documented mileage. Budget amounts were taken from 1982 budget.

Benefit calculations: Figures for costs of worker benefits are calculated below. Average benefits package for Home Care is 20% of total salaries.

Valerie: Monthly salary= $1076.92 x .20= 215.38 total monthly benefits package.

This is then divided by 30 clients= 7.18/mo/client.

Project Director: Salary/hr.= $4.11 paid by project x .20= .822¢

This number x 16hrs./mo. =$13.15 then divided by 30 clients=

44¢/client/month.

:$10.91 salary x .20= $2.18 benefits/hr. x 12 hrs./mo.=$26.18 which

is then divided by 30 clients= 87¢/client/month

Secretary: $4.83 hr. x .20= .966¢ x 30 hrs of work to project= 28.98 divided by

30 clients= $.97¢/client/month

Accounting Staff: Total salaries =$556.43 week x 4= 2225.72/month . This number

x .20 = $445.14 total monthly benefit package. This is then

divided by 1950 clients in the agency= 23¢/client/month.

Conclusions: From the data, one can see that some cases (ex. WDA/EAG) require more time and a greater number of services. Still these are the most needy cases, the other cases documented are characteristic of the number classification they are designated. Thus, it is the conclusion of this study that costs attributed to the project are not substantially greater than that of the rest of Elder Home Care. Furthermore, except for those number four cases (approximately 7 presently), most cases only incur the normal costs of any other case in the agency. overhead costs given here being used as an educated guess to be relatively the same throughout Elder Home Care of Worcester.

ELDER ABUSE AND NEGLECT: FINAL REPORT FROM THREE MODEL PROJECTS

Rosalie S. Wolf
Michael A. Godkin
Karl A. Pillemer

submitted to
Massachusetts Department of Elder Affairs
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APPENDIX II

December, 1984
University Center on Aging
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, Massachusetts 01605

APPENDIX II

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EXHIBIT 1

PRELIMINARY FINDINGS FROM THREE MODEL PROJECTS ON ELDERLY ABUSE

Rosalie S. Wolf
Cecile P. Strugnell
Michael A. Godkin

December, 1982
University Center on Aging
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, Massachusetts 01605

MODEL PROJECTS ON ELDERLY ABUSE*

Massachusetts Department of Elder Affairs

Secretary of Elder Affairs: Thomas H.D. Mahoney, Ph.D.
Project Director: Lillian P. Glickman, Ph.D.
Boston Site Director: Gail Valentinsen, M.A.
Worcester Site Director: Edward R. McCarthy, M.S.W.

Metropolitan Commission on Aging of Onondaga County (NY)

Director: Roslyn Bilford
Project Director: Patricia Cridland, M.S.W.

Rhode Island Department of Elderly Affairs

Director: Anna M. Tucker
Project Director: Joyce M. Hall, M.A.

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* supported by Title IV-C (Older Americans Act) grants from the Administration on Aging.

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Preface and Acknowledgements

This report is the first of a series to be produced as part of the evaluation of the three Model Projects on Elderly Abuse supported by the Administration on Aging. It contains the methodology and findings of community surveys conducted by the Model Projects in 1981 as well as a review of previous research on the subject and proposed theories of causation. Subsequent documents will include the results of follow-up surveys scheduled for 1983, analyses of abuse/neglect cases handled by the Model Projects from July 1, 1981-June 30, 1983, descriptions of the organizational models and curricula for training agency personnel in prevention and intervention strategies.

To plan and carry out a project of this scope requires the cooperation, assistance and guidance of many individuals. Sincere appreciation is extended to the Directors of the three sponsoring organizations and the Model Project Directors and Staff; to the Project Officer of Region I Administration on Aging; and to the many agency personnel who responded to the community survey. Also, the Staff of the Center on Aging at the University of Massachusetts Medical Center deserve a special word of gratitude for conscientious and devoted service.

Rosalie S. Wolf
Cecile P. Strugnell
Michael A. Godkin

I. BACKGROUND

A. Introduction

In the summer of 1980, guidelines for the Title IV-C Model Projects were issued by the Administration on Aging, designating elder abuse and neglect as one of the priority demonstration areas. Over two years had passed since University of Delaware researcher, Suzanne K. Steinmetz (1978), first startled the House sub-committee with her report on "battered parents". Evidence from the early studies and the investigation by the House Select Committee on Aging which followed Dr. Steinmetz's testimony indicated that elder abuse was occurring nationwide and that the incidence was increasing. Although these research efforts provided documentation about the characteristics of the victims, perpetrators and abuse/neglect situations, the number of cases involved in the studies was small, the definitions of abuse and neglect variable, and the discussions concerning prevention and treatment only speculative. Because of the sense of urgency associated with the problem and a decision that "the paucity of data should not be used as a reason to delay implementation of experimental model programs to treat and prevent abuse", the Administration on Aging (1980) allocated a portion of its 1980 discretionary funds to support several Model Projects. Their primary purpose would be:

- to determine the extent of elderly abuse in a geographic area;
- to develop knowledge of existing responses;
- to demonstrate improved mechanisms for reporting and investigating treatment and prevention; and
- to design social and legal remedies to restore rights and well being of abused elderly;

and, secondarily,

- to increase public awareness of the prevalence of the problem;
- to improve reporting to authorities; and
- to institute community wide programs utilizing existing public and private sector services to reduce the incidence of abuse.

The Study and treatment activities would be limited to the abuse and/or neglect of persons 60 years and older by informal care givers in domestic settings.

B. Model Projects on Elderly Abuse

Of the many organizations that responded to the request for proposals issued by the Administration on Aging (AOA), four were selected for funding: the Boston Commission on Affairs of the Elderly, the Massachusetts Department of Elder Affairs, the Metropolitan Commission on Aging of Onondaga County (NY), and the Rhode Island Department of Elderly Affairs. Rather than support two separate programs in Massachusetts, the AOA negotiated with the Boston Commission and the Department of Elder Affairs, and a revised version of the Commission's proposal was incorporated into the Department's program. A brief description of the Projects and their objectives are given below.

Massachusetts Department of Elder Affairs

The Massachusetts Department of Elder Affairs had been engaged in both the study and treatment of the problem for several years. In 1978, it financed a state survey of professionals and paraprofessionals on the maltreatment of elderly. Conducted by Legal Research and Services for the

Elderly of Boston (LRSE) (O'Malley, Segars, Perex, Mitchell, and Kneupfal, 1979) the survey documented the existence of elder abuse in the state. The Department also supported a community based agency, Elder Home Care Services of the Worcester Area* that had developed a crisis intervention program which served abused elders.

According to the Massachusetts proposal, two models for service delivery would be tested: one, a special elder abuse unit organized within the Elder Home Care Services of Worcester Area, which would extend the agency's case management capability to include interagency agreements for 24 hour response, temporary shelter, family counseling and other needed services. The other would be a coordinated elder abuse response system created by the Boston Commission on Affairs of the Elderly, which would include a hot line, case planning protocol, and identification and funding of "gap filling" services. A team from the Center on Aging at the University of Massachusetts Medical Center (UMMC) would serve as project evaluators. The objectives of the Massachusetts program were:

- to plan and develop coordinated elder abuse and neglect programs in the cities of Boston and Worcester, to include health, mental health, social and legal services, housing and to include services to abusers as well as abused and neglected elders;
- to develop and implement a training program for provider agencies and direct service workers;
- to evaluate the activities and results of the entire project and the site activities in the two cities; and
- to disseminate project information and results nationally and within the Commonwealth.

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*Elder Home Care Services of Worcester Area, Inc. is one of 27 non-profit corporations located throughout Massachusetts which provide home-based social services (homemaker, chore, transportation, etc.) to eligible persons 60 years and older. Funds for the programs are provided by the state through the Massachusetts Department of Elder Affairs. "Home Care" when used later in this text refers to these special agencies.

Metropolitan Commission on Aging of Onondaga County (NY)*

The Commission proposed to design and implement a comprehensive and coordinated service system building on the existing community human service infrastructure. For administrative and operational purposes, the project would be sub-contracted to Alliance, a local affiliate of Catholic Charities of Syracuse with experience in the delivery of comprehensive and coordinated services for the treatment of child abuse. The objectives as specified in the Commission's proposal were:

- o to work with the community's socio-legal system for the development of comprehensive and coordinated network for the prevention and treatment of elderly abuse;
- o to develop and facilitate linkages for the utilization of prevention and treatment services through comprehensive and coordinated educational efforts;
- o to initiate service intervention for the prevention and treatment of elderly abuse;
- o to design, develop and implement a data system for the gathering of information on the prevalence of abuse, predictors of abuse, and the utilization and effectiveness of service delivery; and
- o to develop and organize these activities necessary to establish an organizational entity for the administration and operation of the project and to engage in those activities to ensure ongoing organizational and programmatic functioning.

Rhode Island Department of Elderly Affairs

As both a statewide Area Agency on Aging and a State Unit on Aging, the Rhode Island Department of Elderly Affairs provided an opportunity to demonstrate a state-wide comprehensive response system for elderly abuse. In its application to AOA, the Department proposed to develop a data base documenting the prevalence of elder abuse, to increase public awareness, to provide coordination and linkages for a reporting system and to offer counseling and assistance to the abused and abuser. A series of program tasks were set forth as their objectives:

---

*called "Syracuse Project/Site" in the text

- Increase community sensitivity to the problem of elderly abuse by utilization of the media;
- Develop and present to elderly groups a play concerning elderly abuse;
- Provide a hot-line service for any Rhode Islander who wishes to report a possible elderly abuse case;
- Provide domestic violence training to aging network personnel, law enforcement personnel, and other social service agency personnel;
- Provide emergency shelter to elderly who are victims of abuse and who may need immediate care;
- Provide counseling and intervention to elderly abuse victims or potential abuse victims and their abusers;
- Provide outreach to all reported cases of suspected elderly abuse;
- Develop inter-agency coordination and community linkages to maximize the delivery of quality and cost efficient services;
- Encourage and assist in the development and implementation of temporary live-in shelters for elderly who are victims of abuse, and
- Develop a research instrument to measure the type and incidence of abuse among the elderly.

For the most part the Model Projects are located in urban settings with higher than the national average elderly populations. The service area of Elder Home Care encompasses the City of Worcester and 15 surrounding towns, part suburban and part rural with 51,904 persons 60 years and older, or about 18.4 percent of the total population. The City of Boston, the second site for the Massachusetts Department of Elder Affairs Model Project, has 95,262 individuals 60 years and older comprising 17.0 percent of the city population. Onondaga County, the locale of the second Model Project, which includes the city of Syracuse, is inhabited by 71,792 60 year olds representing 15.5 percent of the county populace while the third

Model Project encompasses the entire state of Rhode Island and 176,373 adults 60 years and older or 18.6 percent of the state citizenry.

C. Evaluation Plan

Although the proposals from the Metropolitan Commission on Aging (Syracuse) and Rhode Island Department of Elderly Affairs contained references to the development of a data system and collection of information on prevalence and incidence of abuse, only the Massachusetts Department of Elder Affairs application included an evaluation plan. Prepared by a team from the Center on Aging of the University of Massachusetts Medical Center (UMMC), this component was designed to answer a series of researchable questions, derived from the project propositions and objectives:

- What are the nature and extent of elder abuse in the geographic areas?
- What is the impact of the outreach and case finding techniques on the reporting of elder abuse cases in the geographic areas?
- What is the impact of the Model Project on elder abuse in the geographic area?
- What is the impact of the dissemination of information from the Elder Abuse Project in the state and nationally on the development of programs dealing with elder abuse?
- Is the Model Project a viable and replicable model?
- Is the Model Project an efficient model?

With the inclusion of the Boston site, the plan was expanded to provide information about elder abuse in the city of Boston and to assess the impact of a coordinated response system to be developed by the Bostom Commission on Affairs of the Elderly.

At a meeting of all the Model Project Directors in Boston, called by the Region I AOA office early in 1981, the evaluation team presented their preliminary forms and definitions. The interest of the Syracuse and Rhode Island staff in using these materials led to the development by the UMMC team of a single evaluation methodology for the three Model Projects. A common framework for the evaluation of all site projects was established by incorporating all project objectives into a set of three Evaluation Objectives:

- to determine the nature and extent of elderly abuse in a geographic area;
- to assess the effectiveness of education/training/information dissemination activities; and
- to measure the impact of the intervention model.

The purpose of this preliminary report is to describe the initial phase of the evaluation research which was carried out in four sites during the first year of the grant period. Since the methodology builds on the work of previous investigators, the next section of this document is devoted to a review of the past major studies on the problem, a discussion of some of their limitations, and a presentation of some of the proposed theories of causation.

II. LITERATURE REVIEW

A. Findings from Earlier Studies

In the following section, the four studies, which played a major role in defining the problem of elder abuse, and two more recent efforts, are summarized. Although limited in terms of conceptualization of the problem and the methodology for investigating the causes, they do substantiate the existence of elder abuse, offer some theoretical basis for its occurrence, and provide examples of prevention and treatment procedures.

Cleveland Report

In a paper, "Abuse of the Elderly by Informal Caregivers", presented at the 31st Annual Meeting of the Gerontological Society of America in November 1978, Elizabeth Lau and Jordan Kosberg (1978) describe an exploratory study of elderly clients of the Chronic Illness Center in Cleveland living in the community who were victims of abuse by family or surrogate family members. Their retrospective search of records for a 12 month period revealed 404 clients 60 years and older, of whom 39 or 9.6 percent were victims of abuse. Their definition of abuse included physical abuse (beating, withholding personal care, food and medical treatment; and lack of supervision); psychological abuse (verbal assaults and threats, provoking fear and isolation); material abuse (monetary or material theft or misuse); and violation of rights (being forced out of one's dwelling or into another setting).

Physical abuse was the predominant type of maltreatment in their sample, occurring in 74 percent of the cases, compared with 51 percent for psychological abuse, 31 percent for material abuse, and 19 percent for violation of rights, which usually accompanied other forms. Among the victims, 77 percent were female, and three quarters suffered from at least one major physical or mental impairment. Among the abusers, 27 percent were daughters, 16 percent sons and granddaughters and 15 percent, husbands. Twenty nine percent of the clients accepted professional assistance; 26 percent refused help. The remaining 47 percent were eventually institutionalized. The authors state the need to obtain the most accurate and complete information about a suspected abuse case and to establish a positive relationship as the first steps in the intervention process. Counseling, engagement of other relatives or homemakers, regular nursing and medical care can help reduce the stress in the household for the abused and abuser and assist in maintaining the elderly person in the community.

Maryland Study

The results of a second study was published by the Center of Aging at the University of Maryland in a report entitled, "The Battered Elder Syndrome: An Exploratory Study". Edited by Marilyn R. Block and Jan D. Sinnott (1979), it included a comprehensive review of the literature on intrafamily violence and a discussion of its applicability to elder abuse, followed by the findings from three surveys undertaken in the Baltimore-Washington, D.C. area to determine the feasibility of different approaches to investigating the nature and extent of elder abuse.

Abuse in this study is also categorized into four types: physical, psychological, material and medical. The latter is defined as withholding of medicine or aids, such as eye glasses or false teeth. Using information from their mail surveys of professionals and community elders, these investigators found abused elders to be generally 75 years or older and female (81 percent). Almost the entire sample (96 percent) had some physical incapacity related to activities of daily living and about one third (35 percent) had moderate mental impairment. Fifty-eight percent of the cases belonged to the middle class. The abusers were often relatives, female rather than male. Forty-two percent were children, including in-laws, and 15 percent were spouses. Psychological abuse (58 percent) was more common than physical (38 percent), but almost half the group (46 percent) were victims of the misuse of money or property.

In their discussion of intervention strategies, the authors note that action may involve social services, civil sanctions and criminal proceedings. The most frequent referral for their cases was a public social service agency. They also emphasized a thorough investigation of the complaint as the first step in confirming the existence of the problem and determining the course of action to follow. While institutionalization, they added, may be the least favorable social service intervention, there are cases where removal of the victim from the home situation is the only solution.

Massachusetts Survey

A third study, "Elder Abuse in Massachusetts: a Survey of Professionals and Paraprofessionals", prepared by the staff of Legal Research and Services for the Elderly (O'Malley et al., 1979) presents information about the victim of abuse, the perpetrator and the abuse situation as well as the professionals who encounter it and their responses. The findings were based on a survey of 1044 professionals requesting information on abuse cases for the previous 18 month period. About one-third of the group responded (355), citing 183 cases.

Abuse in this study is defined broadly to include willful infliction of physical pain, injury or debilitating mental anguish, unreasonable confinement or willful deprivation of services which are necessary to maintain mental and physical health. The typical victim was found to be over 75 years of age rather than between 65 and 75, and female rather than male. Three-quarters of the cases had mental or physical performance decrements related to activities of daily living. Abusers were relatives in 84 percent of the cases. Almost three-quarters of the respondents stated that the abuser were experiencing some form of stress such as alcoholism, drug addiction, long term medical complaint or financial difficulties. Over 41 percent of the reported abuse involved physical trauma, including bruises, welts, cuts, and punctures, while mental anguish accounted for 24 percent.

According to the information about the 183 cases, there was a wide variety of actions taken by the respondents. In half the cases, referrals were made to other service agencies and in one-fifth, action was of an emergency nature. The single most often cited action was removal of the victim, either placement in another setting or hospitalization, which occurred in almost 22 percent of the cases.

Michigan Project

Authored by the University of Michigan Institue of Gerontology research team of Richard L. Douglass, Tom Hickey and Catherine Noel (1980), the fourth monograph, "A Study of Maltreatment of Elderly and Other Vulnerable Adults" contains the results of a survey of direct service practitioners regarding their experience and practice with elder abuse and neglect in selected areas in Michigan. In the study, Douglass, Hickey and Noel have included active and passive neglect as two of the four major categories of abuse. Passive neglect includes being ignored, left alone, isolated, or forgotten. Active neglect includes having necessary things withheld such as companionship, medicine, food, exercise, or assistance in toileting. The other category, verbal or emotional abuse includes being called names, treated as a child, frightened, humiliated, intimidated, or threatened while physical abuse means being hit bruised, molested, etc. In order of frequency of reporting from the respondents, passive neglect was found to occur more often than active; verbal emotional abuse was next, followed by active neglect and finally physical abuse. While many of the respondents cited little or no direct experience with physical or verbal abuse or active neglect, over half of them were familiar with cases of passive neglect.

The authors also note that different professional groups reported experience with different types of abuse, perhaps due to the particular settings, training and perspectives which they represent. Their recommendation concerning intervention was to make sure that adequate and acceptable forms of assistance be made available to families living in stressful or potentially explosive situations.

House Select Committee on Aging Investigation

As concern and indignation about the problem of elder abuse mounted in the Nation, the House Select Committee on Aging initiated a series of public hearings in 1979-80 and a year-long full scale national investigation. Their findings issued in Elder Abuse (A Hidden Problem) (U.S. House of Representatives, 1981) includes a discussion on the nature and extent of abuse, a survey of action by state and federal governmental units, and suggested policy alternatives at the federal, state and local levels.

Abuse, for these authors, is subdivided into physical injury, negligence and sexual abuse; financial exploitation; psychological; violation of rights; and self abuse. Based on their investigation and review of governmental documents and research findings, they conclude that physical violence is the most common form of abuse (including negligence), followed by financial abuse, abrogation of basic constitutional rights, and psychological abuse, which occurs simultaneously with other forms. The victims are most likely to be very old, female, and dependent on others for care and protection.

The House document states that while one out of three child abuse cases is reported, only one of six of adult abuse comes to the attention of the authorities. The Committee also concluded that 4 percent of the nation's elderly may be victims of some sort of abuse. Sons are more frequently perpetrators (21 percent), followed by daughters (17 percent). Alcoholism, drug addiction, marital problems, and long term financial difficulties are the primary causes of stress. The report ends with a series of suggested policy alternatives at the federal, state and local levels, including consideration of federal legislation which would provide for financial support for programs of prevention, identification, and treatment of cases of elder abuse, neglect and exploitation and establishment of a

National Center for Elder Abuse whose task it would be to develop a model state elder abuse statute.

Andrus Foundation Research

Since the initiation of the Model Projects, the results of another study have been published. Focusing on the victims of abuse and their families, Mary C. Sengstock and Jersey Liang (1982) of Wayne State University in an Andrus Foundation supported project, "Identifying and Characterizing Elderly Abuse" provide further evidence about the characteristics of elder abuse, the difficulties in identification of cases, and the variability in the quality of services given to victims. This research team describes elder abuse as physical abuse (slaps, punches, etc.) and physical neglect (the failure to provide necessities of life) and psychological abuse (direct verbal assaults and threats) and psychological or emotional neglect (isolation or lack of attention).

Questionnaires were mailed to 302 Detroit area agencies dealing with the elderly. Approximately one-third (36 percent) responded, providing information on 77 cases. Further information was obtained by interviewing persons involved in 20 of the cases. The authors found that about one-third of the cases were 80 years or older and three-quarters (74 percent) were female. Physical and emotional impairments were found in about 22 percent of the cases. Eighty percent had incomes of $10,000 or less. Almost half (49 percent) of the abusers were children of the victim, with sons accounting for 26 percent and daughters 23 percent. About one in eight were spouses. Among the cases in the sample, the most often cited type of abuse was psychological, occurring more than four-fifths (82 percent); financial was found in more than half (55 percent) and physical in

43 percent. Psychological abuse accompanied other types of abuse. In discussing the various intervention strategies the authors state that effectiveness of services seems to be highly dependent on the characteristics of the agency and the worker.

B. Limitations in Research in Elder Abuse and Neglect

Although these investigations have helped to frame the issues, there still remains a high degree of uncertainty as to the nature and extent of elder abuse. First, as evidenced in the preceding pages, there has been confusion and disagreement around the definition of abuse and neglect. Each research team has developed its own meanings for the terms, resulting in a lack of comparability among the findings. Further difficulty in comparing results of the various studies stems from the different criteria used for sample selection. Most researchers have chosen to include persons 60 years and over. However, Douglass, Hickey and Noel (1980) have considered all vulnerable adults as subjects for their work. Other variations relate to residence. Some investigators restricted their sample to elders living in the same house as the care giver (Block and Sinnott, 1979) while Douglass et al. (1980) and O'Malley et al. (1979) include old people who have been abused and living in "non-institutional settings."

Sample size is also a matter of concern. Lau and Kosberg (1979) furnish data on 39 cases, and Block and Sinnott, (1979) on 26. Although the Massachusetts survey (O'Malley et al., 1979) included 183 cases, they do not represent an unduplicated count. The absence of control groups raises still another question about the validity of the findings and the applicability to the general public (Villmore and Bergman, 1981).

Another serious drawback to the earlier studies is the fact that data are based primarily on reports by professional staff members of the agencies likely to encounter abuse. The mode of selection has varied by type of professionals and categories of agencies (O'Malley et al., 1979; Block and Sinnott, 1979; Sengstock and Liang, 1982; Douglass et al., 1979). One group restricted the sample to records of patients of a chronic illness center (Lau and Kosberg, 1979); several collected data from the records of a wide variety of agencies serving the elderly (Block and Sinnott, 1979; O'Malley et al., 1979, Sengstock and Liang, 1982) and one interviewed practitioners (Douglass et al., 1979). Because of the reliance on professional reporting and agency records, it has not been possible to generalize the findings. One attempt at a community survey (Block and Sinnott, 1979) yielded a 16 percent response rate.

Even the type of professional most likely to report abuse varies from study to study, probably depending on the resources of the particular locality. In the Massachusetts survey (O'Malley et al., 1979), the typical respondents were home care corporation staff; in Michigan (Douglass et al., 1979), social workers; and in the Wayne State research (Sengstock and Liang, 1982), legal services personnel. The studies are also limited in their consideration of treatment strategies. Except for the Massachusetts survey, which asked the respondents for information about the action taken, none of the reports furnish much data beyond characterization of the abused, abuser and the situation, although they all include suggestions on intervention and policy recommendations for prevention and treatment.

C. Theories of Elder Abuse

After reviewing the early works described above, Villomare and Bergman (1981) in their manual, Elder Abuse: A Guide for Practitioners and Policy Makers offer the following list of major causes of elder abuse: impairment which leads to dependency and perhaps to a learned helplessness response in the elder; individual pathologies; internal family dynamics including failure to resolve a filial crisis and increased stress in caring for a disabled family member; external stress, such as income and employment problems; and negative attitudes toward the elderly and the disabled. Still another set of explanations for elder abuse, which also draws on the findings from those early studies, is found in the House Select Committee on Aging report (1981). They cite retaliation, aggression and violence as a way of life in America; lack of close family ties; lack of financial resources; resentment of dependency; increased life expectancy; lack of community resources; stress and other life crises, such as unemployment and environmental conditions; and history of personal and mental problems, such as alcoholism and drug abuse.

It is evident from both lists that elder abuse is viewed as a multifaceted problem which can be traced to a number of causes: societal, familial, interpersonal or individual in origin. In trying to find a theoretical basis for elder abuse, most researchers have turned to the literature on family violence. Gelles and Straus (1979) have summarized the findings under three major types of theories: intra-individual, social-psychological and socio-cultural. Within each of these categories, there are several theories which have applicability to elder abuse.

Intra-individual Theories

Intra-individual theories explain family violence in terms of characteristics of the individual actors; the perpetrator and the victim. In the case of elder abuse, mental illness, and/or alcohol abuse by the perpetrator have frequently been thought to be primary causes. The relationship between use of alcohol and violent behavior, however, has been qualified by two research teams (MacAndres and Edgerton, 1969; Gelles, 1974), who propose that association between violence and alcohol may not be a function of the disinhibiting properties of alcohol, but rather that being drunk may provide individuals with a convenient excuse for their behavior. Still other cases of abuse have been attributed to ignorance and the inability to care for the disabled older person (Douglass et al., 1980). Victim characteristics also have been found to precipitate abuse (Douglass et al., 1980; Sengstock and Liang, 1982). Gelles and Straus (1979) point out that these theories explain only a limited number of cases.

Social-Psychological Theories

Aggression-Frustration Theory. Dependence of elders has been observed as causing considerable stress to family caretakers which could lead to aggression, i.e. physical or psychological abuse or withdrawal in the form of neglect (Douglass et al., 1980; Steinmetz, 1981; Sengstock and Liang, 1982). One special source of stress for an adult child caring for a parent is the role reversal that occurs when the younger person takes on the caretaking role (Blenkner, 1979; Steinmetz, 1981).

Social Learning Theory. Gelles and Straus (1979) reject the above theory to the extent that it assumes aggression to be an innate response rather than, as they suggest, a learned response, and thus a particular application of social learning theory. In some societies, frustration leads to withdrawal rather than aggression. The family in particular has been identified as the major training ground for violence (Straus and Steinmetz, 1974). Hickey's life cycle model for understanding neglect (1981) is an example of social learning theory. It refers to dysfunctional learning and socialization patterns in childhood as the underlying cause of the mistreatment of elders. Some individuals, in the absence of new learning processes, are incapable of developing integrated or positive human relationships. Various self-protective, emotional devices help many such individuals cope with their personal responsibilities and low self images such as blaming others (which could lead to aggression), or avoidance of close personal relationships, particularly if they become troublesome (which might lead to neglect of an elder).

Exchange Theory (Blau, 1964; Homans, 1961) is based on the assumption that interaction is guided by the pursuit of rewards and the avoidance of punishments or costs. As long as the reciprocal exchange of rewards occurs, the interaction will continue, but if the reciprocity is no longer achieved, the interaction is broken off. Caretaking of one's elders can become an unending and thankless task which, according to this theory, might lead to severance of the relationship, and thereby to neglect. Homans (1961) links this theory with the notion of "distributive justice." When individuals do not receive just rewards for their activity, they become angry. The resulting aggressive behavior can be a rewarding experience. This aspect of the theory would explain physical or psychological abuse. Exchange theory has not been applied to elder abuse, but Cicirelli (1981) uses it in his study of helping patterns of children and their elderly parents. He suggests that if adult children are to be motivated in their caretaking role, some reward should be offered by society since the parent can no longer reciprocate.

Socio-cultural Theories

Functional Theory asserts that violence, although it causes injury, and sometimes death, can fulfill certain important social functions. Specifically, Coser (1967) mentions it can serve as a danger signal within the system or act as a catalyst for action of non-participants or observers. In some families, violence serves as a means of communication. It is a signal by the aggressing party that things have become intolerable, and if the condition deteriorates further, a way of attracting the attention of agents outside the family (police, social services, etc.) for help (Straus and Steinmetz, 1974). This theory obviously would also apply to physical violence inflicted on old people "to make them mind" (Steinmetz, 1981), but could also be expanded to include such forms of abuse as physical restraints and neglect, which may also draw the attention of outside helpers.

Culture of Violence Theory proposes that violence is learned as a part of the value system in a certain subculture and thus may be considered as a further extension of the Social Learning Theory. However, it does not explain how such subcultures are formed. If elders were highly valued, violence against them would probably not be admissable. Several authors have referred to the impact of ageism in our society as contributing to abuse of elders and have specified that these derogatory views of elderly are shared by the victims themselves (Davidson, Hennessey, and Sedge, 1979).

Structural Theory of Violence postulates that violence will be more prevalent among those occupying certain structural positions that are likely to provoke unusual frustration (Gil, 1970). Economic and demographic factors may lead to increasing burdens on families caring for elders. Hickey (1979) views structural factors as potential stress points and triggers of negative behavior for individuals with underlying dysfunctional development. Sengstock and Liang (1982) suggest that abusive families have few social resources to call on when stressful situations occur.

Conflict Theory states that individuals in society pursue their own interests with conflict as a natural outcome. There are many ways of handling conflicts. For some families, violence is the means of first choice. For others, it is used as a last resort when other methods of achieving special interests breakdown (Straus and Steinmetz, 1974). In some cases, it results in withdrawal, which would explain neglect.

Intrafamilial Resource Theory is based on the assumption that all social systems rest to some degree on force or threat (Goode, 1971). It argues that the individual who has greater access to resources will not need to actually deploy his strength in an overt manner. On the other hand, violence is used when other resources are insufficient or missing. This theory might apply to situations where family members lack resources such as money, employment, and prestige (Block and Sinnott, 1979) and seek to maintain their position in the family by manifestations of violence, which are most likely to be turned against the most powerless: the children and the elders. Sengstock (1982) has reported that families abusive of old people are often isolated therefore lacking access to social support systems. This condition has also been observed in other cases of family violence (Case and Lesnoff-Caravaglia, 1978).

The multiplicity of possible theoretical explanations is indicative of the complexity of the situations which are associated with elder abuse and neglect. At this stage in the research, the data are insufficient for confirming or refuting the theories. Even though the evaluation activities to be described in the following pages are less rigorous in conceptualization and implementation than projects primarily intended for research purposes, they provide an opportunity to study the issues related to the identification and treatment of elder abuse and neglect and to generate data for testing the theories.

III. METHODOLOGY

As noted earlier, the objectives of the of the Model Project evaluation are derived from the propositions and objectives of the individual Projects which have been integrated into a common framework:

- to determine the nature and extent of elderly abuse in a geographic area
- to assess the effectiveness of education/training/information dissemination activities
- to measure the impact of the intervention model

In order to obtain information concerning elder abuse and neglect from the sites and to collect the baseline data that could be used to measure the effectiveness and impact of the Model Project activities, a community survey was organized during the first year of the grant period. A description of abuse and neglect, instrument design, and data collection is presented below.

A. Definition of Abuse and Neglect

Once a decision had been made to incorporate all three Model Projects into one evaluation plan, it was necessary to establish a working definition of elder abuse and neglect which would be acceptable and applicable to all three programs. In its grant application, the Massachusetts Department of Elder Affairs used the abuse/neglect definition from the LRSE survey:

> Abuse is the "willful infliction (on elders) of physical pain, injury or debilitating mental anguish, unreasonable confinement, or willful deprivation by a caretaker of services which are necessary to maintain mental and physical health."

The Syracuse Model Project staff had adopted the following description:

Physical abuse: direct beating, lack of food, lack of medical care, lack of supervision

Psychological Abuse: verbal assaults, threats, causing fear, isolation

Material abuse: theft, misuse of money or property

Violation of rights: forced removal from home or forced entry into a nursing home.

Still another interpretation had been given by the Rhode Island group:

Physical abuse: willful infliction of physical pain, injury, mental anguish or harm or willful denial of service necessary to maintain physical and mental health of the person by the party or parties responsible to and for the person abused

Neglect: person not receiving essential services required for maintaining physical and mental health from the responsible part or parties

Exploitation: taking advantage of elder person by illegal or improper use of that person's resources for profit or advantage

Abandonment: desertion or willful foresaking of an aged person by responsible party or parties or foregoing of duties and obligations owed an elder person.

So that the various meanings above as well as those that had appeared in previous studies could be accommodated within a single definition, five sub-categories were created: physical, psychological and material abuse and active and passive. See Figure 1. For the purpose of this study, "nature of abuse" was characterized by these five categories. "Extent of abuse" was used to mean both severity and prevalence. Severity was measured by the specific manifestations of abuse (as was done in the LRSE Survey of Massachusetts) and by regularity of occurrence. Since it was not possible within the scope of the Model Projects to include a sampling of the general population, prevalence was interpreted to be the proportion

Figure 1

ABUSE

physical	-the infliction of physical pain or injury, physical coercion (confinement against one's will) example: slapped, bruised, sexually molested, cut, burned, physically restrained, etc.
psychological	-the infliction of mental anguish example: called names, treated as child, frightened, humiliated, intimidted threatened, isolated, etc.
material	-the illegal or improper exploitation and/or use of funds or other resources

NEGLECT

active	-refusal or failure to fulfill a caretaking obligation, INCLUDING a conscious and intentional attempt to inflict physical or emotional distress on the elder example: deliberate abandonment or deliberate denial of food or health-related services
passive	-refusal or failure to fulfill a caretaking obligation, EXCLUDING a conscious and intentional attempt to inflict physical or emotional distress on the elder example: abandonment, non-provision of food, or health related services because of inadequate knowledge, laziness, infirmity or disputing the value of prescribed service

of abuse cases to the total number of elderly cases for the reporting agency.

B. Data Collection

Worcester

After a study of instruments used in previous elder abuse surveys and consultation with the Worcester site project staff, an Agency Report form was designed for distribution to the staff of health mental health, social service, legal, and law enforcement agencies in the Worcester area. It included questions on awareness of elder abuse, reluctance or willingness to report, and the number of cases of abuse/neglect with which the agency had been involved in the previous six month period, as well as the number of "self abuse cases". Attached to the Agency Report were several Individual Case Report forms which requested specific data on the individual client, the abuse situation, the abuser and the action taken by the agency. One of the distinctive features of the Individual Case Report was the provision for coding the client's name so that forms completed on the same person by more than one agency could be identified.

In order to judge the suitability of the Agency and Individual Case Report, a pre-test was arranged with 14 agencies in the Worcester area. Two groups were approached; those that had an on-going relationship with the Worcester Model Project (Elder Home Care Services of Worcester) and were familiar with the program and a similar set of agencies that had little or no contact with Elder Home Care or knowledge of the abuse study. Of the 14 receiving the forms, 11 responded, all of the former and 4 of the latter group. The general reaction as expressed by one respondent, was "that the Survey was thorough while at the same time it was easy to move through it". Based on the suggestions from the pre-test, a few minor changes were made in the forms, and then they were mailed out in July, 1981 to 117 agencies. Information was requested for the period October 1, 1980 - March 31, 1981. See Appendix A Exhibits 1-2. Mailing and follow-up were handled by the Evaluation Team.

Boston

The two forms produced for the Worcester survey were reviewed and accepted by the Boston site staff and coordinating committee with several modifications. Concerned that the agencies might be using different definitions of abuse and neglect, the Boston Project Director requested that the following questions be added to the Agency Report:

> Do you recall a client coming to the agency whom you did not consider to be an abuse case, but, according to the definitions on the survey attachment, you now realize was abuse?

Also, the Boston group asked to include:

> "the number of cases of professional abuse in the agency"
>
> "the number of cases of abuse and neglect by type (physical, psychological, material, active and passive neglect), and "combination types"

and to omit "the number of cases of self-neglect". A major addition was a training needs assessment page (Appendix A, Exhibit 3). The six month period chosen for reporting was January 1, 1981 - June 30, 1981. Survey forms were sent to over 200 agencies in the City of Boston in September, 1981 by the Model Project staff.

Syracuse

Both the Agency and Individual Case Reports as developed for the Worcester site were utilized by the Syracuse Model Project with slight variation. The categorization of elder abuse added to the Boston survey form and the training needs assessment were retained in the Syracuse version, but questions pertaining to self-abuse and professional abuse were deleted. The Individual Case Reports were not included with the Agency Reports because the Syracuse Project staff did not have enough time to do the orientation or follow up with the agencies which they believed would be necessary, but were completed by the Model Project unit itself for its clients seen during the reporting period, January 1, 1981 - June 30, 1981. One hundred and twenty five agencies in the Syracuse area (Onondaga County) received survey forms requesting information for the period, January 1, 1981 - June 30, 1981.

Rhode Island

Except for the questions on "professional abuse" and "misidentification of case" which were left off the Agency Report form, the Rhode Island survey was similar to the one used in Boston. Again, because of limited staff time, the Individual Case Reports were not included with the Agency Reports which were distributed by the Department to Rhode Island agencies and organizations in November, 1981. However, they were used for Model Project abuse clients seen by the Department during the first six months of the grant period, January 1, 1981 - June 30, 1981.

IV. RESULTS: THE AGENCY REPORTS

This section presents the findings from the 177 agencies in the four sites that completed the 1981 survey form. This information will serve as base line data for subsequent analyses of educational, preventive, and clinical activities of the Model Projects.

A. Response From Four Sites

Number of Responses and Agency Type (Table 1)

The most successful rate of return of the Agency Reports among the sites was at Worcester (74 percent), where a fairly extensive orientation and follow-up process for the survey were carried out. Prior to submitting the initial application to the Administration on Aging, Elder Home Care had been in contact with over 50 agencies in the area to explain the proposed project and to obtain a commitment to support it. After the receipt of the grant, the Project Coordinator began an outreach program to agencies to describe the program and to prepare the staff for the survey. Within a few weeks after the forms had been mailed to 117 agencies, approximately 50 percent were returned. A second mailing and a telephone call reminder brought in an additional 24 percent. None of the other sites had the staff to do the necessary follow-up. The Boston Model Project staff mailed forms to about 200 agencies (the exact number is not known because of duplication in the mailing lists) and received 68 forms (34 percent) in return. For Syracuse the total was 55, about 53 percent of the 105 agencies that had been contacted. A limited number of telephone calls were made by a college intern to increase the response. Rhode Island mailed 225 and obtained 71 replies (31 percent; twenty-five responses from long term care facilities were excluded from these analyses). Table 1 gives the percentage of returns by agency type for the four sites. Health related institutions (hospitals and health centers) were the major source of completed survey forms in Worcester, Boston, and Rhode Island while the largest number of Syracuse returns came from the local police departments.

Table 1 Type and Number of Agencies Responding to Community Survey

	Worcester	Boston	Syracuse	Rhode Island
	% (n=86)	% (n=68)	% (n=55)	% (n=71)
Health (hospitals, health centers)	20.9	26.5	7.3	28.2
Home health agencies	11.6	7.4	10.9	5.6
Home Care	1.2	4.5	-	-
Housing	-	5.9	3.7	9.9
Elder Services	7.0	5.9	12.8	25.4
Social Services	4.7	7.4	10.9	5.7
Legal Services	3.5	4.5	-	-
Police	16.3	-	25.5	12.7
Boards of Health/ Health Depts.	8.2	-	1.9	-
Councils on Aging	11.7	-	-	-
Mental Health Services	3.5	3.0	3.7	9.9
Churches/Religious Groups	1.2	4.5	16.4	-
State Agencies (DSS,DPH)	1.2	8.9	1.9	-
Neighborhood Centers	4.7	8.8	-	2.9
Day Care Programs	2.4	1.5	-	-
Miscellaneous	2.4	11.8	5.5	1.9

Extent of Elder Abuse and Neglect (Table 2)

The intention in placing the question, "how many elder clients were active cases at your agency in the six month period?" on the survey form was to be able to determine a denominator for calculating the rate of elder abuse within each agency. Less than two thirds of the agencies completing the forms replied to this question of whom one-third reported no elderly clients. Half of the remaining group had active cases of elders numbering between 100-200 or 200-300. Several hospitals counted cases (admissions?) in the thousands.

When asked for number of cases of elder abuse and neglect, the Worcester forms included 94 cases of abuse/neglect by others and 371 cases of self-neglect, with one agency reporting 1 25. The total for Boston in the six month period was 153, including 22 "combinations". In answer to the question concerning the number of cases of abuse in a domestic setting involving professional care-givers, 38 agencies of the 68 in the sample, replied "none", 6 said "yes", citing a total of 17 cases; and 26 did not respond.

Table 2 Number of Elder Abuse/Neglect Cases Reported by Agencies for a Six Month Period***

Types	Worcester (n=27)	Boston (n=24)	Syracuse (n=25)	Rhode Island (n=26)
Physical Abuse		29	46	23
Psychological Abuse		27	65	20
Material Abuse		13	42	16
Active Neglect		7	32	10
Passive Neglect		55	44	18
Combination Abuse		22	8	56
Total Cases Reported	94*	153	262**	
Case of Self-Neglect	371			
Cases of Professional Abuse		17		

*Some of these cases were later found to be self-neglect

**The local Adult Protective Services included a total of 100 cases, 20 in each category

***These numbers may not represent discrete cases because of multiple manifestations of abuse and neglect cases.

The Syracuse forms also asked for the number of cases by types. Twenty four of the agencies that completed the question showed 162 cases of which 8 were "combination types". The Department of Social Services in

Syracuse which houses the Adult Protective Services program listed 100 cases, 20 in each category (which appeared to be an estimate rather than the actual count). Elder abuse/neglect cases were reported by 26 of the agencies responding to the Rhode Island survey. The total number of cases was 143, of which 65 were "combination types".

Knowledge and Reporting of Elder Abuse/Neglect (Tables 3-4)

In trying to determine the level of awareness of elder abuse, the agencies were asked to check either "the agency staff has known at least one case" or "the agency staff is aware of elder/abuse, but has not encountered specific case". Those not answering the question were considered as not having encountered a case and/or not being aware of a case. This group represented less than 4 percent of the agencies in the Worcester, Syracuse and Rhode Island areas and about 24 percent of the Boston organizations.

Table 3 Awareness of Elder Abuse/Neglect Cases

	Worcester % (n=86)	Boston % (n=68)	Syracuse % (n=55)	Rhode Island % (n=71)
Aware, but have encountered no cases	57.8	48.1	48.2	43.3
Known at least one case	42.2	51.9	51.8	56.4
No answer (not aware, not encountered)	(3)	(16)	(2)	(4)

When asked whether they were reluctant to report abuse/neglect cases, most all of the agencies in the four sites checked "not at all". Among the reasons cited by those (n=31) who were "a little" or "very reluctant" to report was "suspicious, but not enough evidence" (11); "confidentiality" (7); "limited success in the past" (5); "lack of receptivity of abused" (5),

Table 4 Reluctance to Report Cases of Elder Abuse/Neglect

	Worcester	Boston	Syracuse	Rhode Island
	%	%	%	%
	(n=86)	(n=68)	(n=55)	(n=71)
Not at all reluctant	91.4	81.6	90.4	87.0
A little reluctant	7.4	16.3	9.6	10.1
Very reluctant	1.2	2.0	-	2.9
No answer	(5)	(19)	(3)	(2)

and "compassion for the abused" (2). Regarding the inquiry on the Boston survey which asked about "mis-identification of cases", only two agencies responded. One stated that an abuse/neglect case had been identified as a "medical problem"; a second agency said that it had labelled an abuse case as "emotional incompetence of the care giver". Of the 33 answers to the question asking for the agency's working definition of abuse/neglect, 9 noted "none". The others reported that their definition would be compatible with that in the survey and offered such examples as: "allowing person to live in degrading circumstances", "any dehumanizing experience" or "anything that interferes with the person's safety".

Community Response System: Hypothetical Cases of Elder Abuse/Neglect (Table 5)

To learn more about the existing system for elder abuse in each site, the survey asked each agency to "name the agencies that you would think of turning to regarding cases of elder abuse and neglect". In the Worcester area, 75.6 percent of the responding group named Elder Home Care (Model percent of the responding group named Elder Home Care (Model Project), 52.3 percent, police; and 38.5 percent, home health organizations. Agencies replying to the Boston survey were more apt to list social services (57.1); then elder services (eg senior centers) exclusive of the home care corporations (55.1); and legal services (24.5). The type of agencies in Syracuse most often cited were the state agencies, predominantly the Department of Social Services Adult Protective Service (71.4); the local health department (49.0); and the local Commission on Aging (32.7). For the state of Rhode Island, the agencies receiving the largest number of responses were the Department of Elderly Affairs (81.2), followed by the police (50.0 percent).

Community Response System: Actual Cases of Elder Abuse/Neglect (Table 6)

When the question was re-worded from the hypothetical case to "If you ever were involved with cases of elder abuse, name the agencies you turned to", approximately half the agencies responded. In the Worcester area, Elder Home Care Services (72.5 percent) and the home health agencies (35.0) remained the most popular choices, but the police dropped from having been selected by 52.3 percent of the respondents to 12.5 percent of those who had been involved with cases. For Boston, the agencies providing legal services received the highest response (36.0 percent) followed by elder services, other than the home care corporations (28.0 percent), and the mental health agencies (28.0 percent). For Syracuse the pattern remained the same. Sixty three percent of the agencies who answered the question had turned to the DSS Adult Protective Services (state agency) and 28.0 percent to the local health department. With respect to the Rhode Island agencies, the action taken most frequently involved the Department of Elderly Affairs (59.8 percent), the police (26.5 percent), and the state agencies, Social and Rehabilitation Services, etc., (26.5 percent).

Table 5 Community Response System for Cases of Elderly Abuse/Neglect

Agency Types	Agencies you "would turn to"	Agencies you "turned to"
	%	%
	(n=78)	(n=40)
Worcester		
Elder Home Care (Model Project)	75.6	72.5
Other elder services	28.2	17.5
Legal services	15.4	22.5
Police	52.3	12.5
Neighborhood health centers	2.6	5.0
Private MDs	1.3	2.5
Home health agencies	38.5	35.0
Councils on Aging	14.1	12.5
Social services	10.3	10.0
Mental health agencies	14.1	17.5
Churches	5.1	2.5
State agencies (DSS)	7.7	10.0
Local health departments	6.4	5.0
Hospitals	14.1	7.5
Judiciary/courts	10.3	7.5
Shelters	2.6	5.0
Other	6.4	10.0
Boston	(n=49)	(n=25)
Home care corporation	18.4	20.0
Other elder services	55.1	28.0
Legal services	24.5	36.0
Police	8.2	12.0
Neighborhood health centers	2.0	4.0
Home health agencies	14.3	16.0
Commission on Affairs of Elderly	6.1	-
Social services	57.1	16.0
Mental health agencies	10.2	28.0
Churches	4.1	-
State agencies (DSS, DPH)	12.2	16.0
Local health department	6.1	8.0
Hospitals	-	24.0
Judiciary/courts	8.2	4.0
Other	2.0	4.0

Service Needs (Table 7)

The survey then asked the agencies that had been involved with cases of elder abuse to list services needed for effective resolution but currently unavailable. The numbers responding to this question were only a small proportion of the group that returned the forms (Worcester, 33.7 percent;

Table 6 Community Response System for Cases of Elderly Abuse/Neglect (cont.)

Agency Types	Agencies you "would turn to"	Agencies you "turned to"
	% (n=47)	% (n=23)
Syracuse		
Alliance (Model Project)	18.4	16.0
Legal services	10.2	16.0
Police	10.2	4.0
Commission on Aging	32.7	4.0
Social services	10.2	-
Mental health agencies	10.2	8.0
State agency (DDS Adult Protective Services)	71.4	68.0
Local health department	49.0	28.0
Hospital	9.0	4.0
Judiciary/Courts	4.0	4.0
Other	6.1	
Rhode Island	(n=64)	(n=34)
Dept. of Elderly Affairs (Model Project)	81.2	58.8
Other elder services	14.1	8.8
Legal Services	4.7	3.0
Police	50.0	26.5
Private MDs	1.6	3.0
Home health agencies	6.3	5.9
Social services	4.7	3.0
Mental health agencies	15.6	23.5
Churches	1.6	5.9
State agencies (SRS, DPW)	12.5	26.5
Local health departments	18.8	11.8
Hospitals	4.7	5.9
Judiciary/courts	1.6	-
Local human resources	4.7	3.0
Other	4.7	11.8

group that returned the forms (Worcester, 33.7 percent; Boston, 26.4 percent; Syracuse, 25.0 percent; and Rhode Island, 31.0 percent). Nevertheless, over 20 types of services were listed. All four sites named "emergency shelter" as the most needed service. Second place was given to respite facilities by the Worcester (27.6 percent) and Syracuse (21.4

percent) respondents; legal services, Boston (27.8 percent); and home health care, Rhode Island (22.2 percent).

Table 7 Services Which Are Needed For Effective Resolution of Cases

Service Types	Worcester % (n=29)	Boston % (n=18)	Syracuse % (n=14)	Rhode Island % (n=22)
Emergency shelter	34.5	44.4	28.6	27.3
Respite facility	27.6	11.1	21.4	9.1
More integration/follow up	10.8	11.1	14.3	18.2
Financial aid	10.3	5.6	14.3	4.5
Public education	3.4	5.6	14.3	13.6
Hot line	6.9	-	-	-
Mandatory reporting	3.4	11.1	14.3	-
Legal services	10.3	27.8	21.4	4.5
Conservatorship programs	10.3	22.2	-	11.1
More inclusive home health	13.8	16.7	-	22.7
Physician home visits	6.9	-	-	-
Housing	6.9	16.7	-	22.7
Better access to meal services	3.4	-	-	-
Service reimbursement	3.4	-	-	-
Peer support/buddy system	6.9	-	14.3	-
Agency/staff education	10.3	-	14.3	-
Counseling	10.3	16.7	14.3	9.1
Crisis intervention program	6.9	5.6	-	13.6
Clergy involvement	-	5.6	-	4.5
Bilingual counseling	-	5.6	-	-
Better elder abuse laws	-	22.2	14.3	18.2

Procedures For Dealing with Abuse/Neglect Cases (Table 8)

Another opportunity to learn about the existing response system to elder abuse in the communities was provided by the question, "Does your agency have a procedure for dealing with suspected cases of abuse?" Answering affirmatively were 34.6 percent of the Worcester respondents, 36.7 percent of the Syracuse group, and 52.3 percent of the Rhode Island group. Closer examination of the procedures outlined by this group revealed that most of them were informal arrangements, as described by one individual

> ...no written procedures, but we would carefully evaluate the situation, underlying causes, etc. and based on those would probably contact DSS Protective Services or other agency which might work with the abusing person (Syracuse).

A few agencies did submit documents which had the procedures defined in a systematic way. When the word "procedure" was changed to "protocol" (a written statement detailing the process for identification and treatment) on the Boston survey form, only 4 percent of the agencies replied "yes".

Table 8 Agency Procedures for Dealing with Cases of Abuse and Neglect

	Worcester	Boston	Syracuse	Rhode Island
	% (n=78)	% (n=49)	% (n=49)	% (n=67)
Yes, the agency does have a procedure for dealing with abuse/neglect cases.	34.6	4.1*	36.7	52.3
No, the agency does not have a procedure for dealing with abuse cases	65.4	95.9	63.3	47.8

*The Boston project survey form substituted the word "protocol" for procedure in the question.

B. Training Needs of Three Sites

In three of the sites (Worcester Area excluded), a training needs assessment was attached to the survey form mailed to the community agencies. Seventy-one percent of the responding Boston agencies completed this portion of the survey; 96 percent of the Syracuse group; and 100 percent of the Rhode Island organizations. Most of the agencies were interested in more training (Boston, 77.1 percent; Syracuse, 79.6 percent; and Rhode Island, 78.5 percent). Among the possible types of personnel who might benefit, direct care/service providers were listed first by Boston and Rhode Island. The Syracuse respondents named supervisors as their top choice and direct care providers, second. Concerning the major topics of interest (rankings of one or two), the Boston agencies listed local resources and legal fundamentals; Syracuse, local resources and potential causes; and Rhode Island overview of abuse and local resources. All three sites chose inservice education as the preferred format for the training. (See Tables 9-10)

Table 9 Interest in Training About Elder Abuse/Neglect

	Boston % (n=48)	Syracuse % (n=49)	Rhode Island % (n=78)
Yes	77.1	79.6	88.5
No	22.9	20.4	11.5

Table 10 Training Needs

	Boston	Syracuse	Rhode Island*
	%	%	%
	(n=35)	(n=38)	(n=77)
If training were made available, what group from your agency should be included?			
Direct care/service providers	82.9	47.4	66.3
Supervisors	71.4	50.0	43.4
Outreach workers	47.1	23.7	28.6
Administrators	20.0	39.5	45.5
Volunteers	20.0	23.7	18.2
Consumers	14.3	13.2	13.0
Others	11.4	26.3	11.7
What topics would be of interest?	(n=35)	(n=41)	(n-77)
Local resources	78.9	78.0	57.2
Legal fundamentals	68.4	58.5	52.0
Prevention strategies	52.6	43.9	46.8
Overview of abuse	52.6	63.4	59.8
Mandatory reporting legislation	50.0	29.3	42.9
Investigation/Intervention	47.4	65.9	55.9
Potential cause of abuse	47.4	68.3	50.7
Conservatorship/guardianship	42.1	22.0	35.1
Intake and referral process	39.5	51.2	46.8
Domestic violence	34.2	22.0	26.0
Case studies	28.9	22.0	32.5
Service models	28.9	24.4	22.1
Theories of abuse	28.9	29.3	31.2
Summary of research findings	13.2	19.5	23.4
Other	2.6	2.4	7.8
What method of training would be most suitable?	(n=38)	(n=40)	(n=76)
Inservice education for agency personnel	47.4	47.5	48.7
Half-day program on specific topics	28.9	17.5	22.4
All day program - multidisciplinary	26.3	30.0	9.3
Seminar series	21.1	15.0	17.1
Workshop for supervisors	15.8	20.0	25.9
Short-term course in skill development	15.8	17.5	7.9
Half-day program - multidisciplinary	5.3	22.5	13.2
Other	2.6	5.0	7.9

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*Several responses from long term care facilities which could not be identified are included.

V. DISCUSSION: AGENCY REPORTS

The purpose of the survey of agencies in the first year of the grant program was to obtain information about the number of cases of elder abuse/neglect, the existing community response system and (in three of the four sites), the training needs of agency personnel. In considering the results, it must be borne in mind that the survey was restricted to human service agencies. Private physicians, lawyers, banks and other groups that come into contact with the elderly were excluded. Also, many of the agencies receiving the forms did not return them. The variation in the number and type of respondents for each geographic area seems to be indicative of the nature of the Model Project sponsor and the linkages which exist between it and the community. The Syracuse project, an affiliate of Catholic Charities, was able to reach a relatively large number of churches because of its relationship with Catholic Charities and the Diocese. Rhode Island, as a state office on aging, could tap into the aging network. The Boston Model project, part of a city agency, had the most success with the hospitals and health centers, while the Worcester Elder Home Care, a non-profit corporation, was able to take advantage of a good working relationship with a wide variety of community groups.

The attempt to calculate a rate of elder abuse/neglect for each reporting agency by determining the proportion of abuse/neglect cases to the total case load was not unsuccessful. Not only was there a problem with the "denominator", but there was difficulty with the "numerator". More than one-third of the agencies did not give their case load, probably because the term "case" was inappropriate (e.g., churches, police, senior centers, etc.) The inadequate data on number and types of abuse cases may have been due to the survey instrument which failed to distinguish adequately between the number of cases and individuals and between abuse/neglect by the caretaker and by self. Another explanation may be the lack of training on the part of the respondent in identifying cases of abuse, although only a few persons chose to respond to the question on the Boston survey concerning misidentification of cases. Still another possibility may be the nature of elder abuse which involves very complex and often unstable situations that cannot be easily classified.

Requesting information from the agencies concerning their source of help for elder abuse cases ("where they would turn or have turned") was included to determine the provider level of awareness of resources as well as to learn more about the community response systems. In most sites, there were slight differences in the responses addressed to the hypothetical and concrete situations, which would suggest a lack of knowledge or experience about cases or resources on the part of the agency personnel or attitudinal bias. For instance, one third of the respondents in the Worcester area said they would turn to the police, although in actuality, a much smaller percentage had done so. It is interesting to note that the constellation of services ordinarily called upon for the treatment of elder abuse and neglect varies among the sites. Because Elder Home Care Services of Worcester had been operating a Crisis Intervention Program for several years, it is expected that it would be named as the most likely agency for dealing with abuse cases. Apparently, the Boston home care corporations play a less important role in elder abuse cases than the social services agencies in the City (Catholic Charitable Bureau, Family Service Organizations) or other elder services, (particularly, the Council of Elders) or legal services. In fact, the latter was named most often by respondents as the type of service most frequently called upon for handling abuse cases, perhaps due to the important role that Boston's Legal Research and Services for the Elderly has played in the field of elder abuse.

In New York State, the Department of Social Service is mandated to provide adult protective services. This responsibility appears to be well known to Syracuse area agencies, since the Department was named most often as the agency "you would turn to" as well as "you had turned to". The local health departments which provide home-based services were also designated as important resources in Onondaga County/ Syracuse area.

For Rhode Island, the Department of Elderly Affairs (also an area agency on aging) is the lead organization with respect to elder abuse. Not only is it the focal point for elderly services in the state but it is authorized under law to receive all reports of aged maltreatment. As with the Worcester survey findings, there appears to be a discrepancy in the importance given to the police in handling abuse cases; in actuality, a smaller proportion of agencies using them than had been assumed.

Generally, the major resources identified with elder abuse in the communities include:

Elder Services/Elder Home Care
Social Services/Adult Protective Services
Home Health Care/Health Departments
Legal Services
Police

The importance of each of these appears to reflect the particular characteristics of the local service delivery system and the kinds of programs which the agencies have developed for abused elders. In some of the sites, legal services played a prominent role; in others; they were almost absent.

Although mental health services were mentioned fairly often by respondents in two of the sites, in comparison to the above resources, they seem to be used less frequently. According to the results of the four surveys, there is an adequate array of resources, except for emergency shelter, which is in short supply in all sites. On the other hand, information about local resources was the most often cited training need. Missing in almost all instances was a protocol to help service personnel identify cases and make appropriate referrals.

VI. RESULTS: INDIVIDUAL CASE REPORTS

Individual Case Reports were completed by community agencies in the Worcester (n=62) area and the City of Boston (n=65) and by the Model Projects in Syracuse (n=28) and Rhode Island (n=22). A comparison of the results from the first two sites is presented below, followed by an analysis using the pooled data from all four localities.

A. A Comparison of Data Findings from Worcester and Boston Sites

Types of Elder Abuse/Neglect Cases (Table 11-13)

The staff of the reporting agencies were asked to classify each case of abuse into one of more of the five categories, according to the set of definitions adopted by the Projects. Table 11 provides a breakdown of the 127 cases reported. Respondents were requested also, to provide details of the nature of the abuse and neglect sustained (See Table 12). In reviewing these data, it was noted that the use of the simple classification scheme to categorize cases did not accurately characterize the nature of the abuse/neglect cases.

Table 11 Classification of Abuse/Neglect Types*

Types	Worcester % (n=62)	Boston % (n=65)
Physical abuse	46.3	47.5
Psychological abuse	61.7	52.5
Material abuse	30.0	28.8
Active neglect	13.3	20.3
Passive neglect	31.7	35.6
No answer	(2)	(6)

*Respondents were asked to indicate the nature of the particular abuse/neglect case, using more than one category if appropriate.

Table 12 Details of Abuse/Neglect Sustained

	Worcester	Boston
	%	%
Physical Abuse	(n=27)	(n=42)
Bruises, welts	70.4	50.0
Sprains, dislocations	3.7	7.2
Malnutrition	18.5	7.2
Burns, scalding	-	2.4
Abrasions, laceration	14.8	16.7
Wounds, cuts, punctures	3.7	-
Internal injuries	3.7	-
Sexually molested	11.1	9.6
Oversedated	3.7	4.8
Hypothermia	3.7	-
Bone fractures	11.1	9.6
Skull fractures	3.7	2.4
Direct beatings	11.1	14.3
Forced into nursing home	3.7	4.8
Tied to bed	-	2.4
Tied to chair	-	2.4
Other physical confinement	11.1	14.3
Other	7.4	23.8
Psychological Abuse	(n=51)	(n=54)
Verbal assault	72.5	66.7
Threat	58.8	48.1
Intimidation	66.7	55.6
Humiliation	47.1	33.3
Isolation	37.3	40.7
Other	11.8	16.7
Material Abuse	(n=35)	(n=30)
Taking possession of money or property of abused/neglected person	50.7	63.1
Misuse of money or property of abused/neglected person	68.6	80.0
Other	11.4	23.3

*Percentages are based on number of cases for which data are reported. More than one manifestation of abuse/neglect may be present in one case.

Table 12 Details of Abuse/Neglect Sustained (cont.)

	Worcester % (n=35)	Boston % (n=38)
Neglect		
Abandoned	5.7	18.4
Lack of help in house cleaning	60.0	15.8
Lack of food	54.3	42.1
Lack of heat	31.4	7.9
Lack of personal care	48.6	47.4
Lack of supervision generally	31.4	42.1
Lack of support/companionship	62.9	65.8
Failure to purchase prescribed medications	5.7	7.9
No false teeth when needed	11.4	2.6
No glasses when needed	8.6	-
Failure to provide other prescribed medical services	5.7	10.5
Failure to fulfill other caretaking obligations	20.0	34.2

For example, a case may not have been designated as physical abuse by a respondent, but for the same case, specific manifestations of physical abuse have been checked. Consequently, the detailed data are used as a second and more valid means of categorization of cases, e.g., cases with some physical abuse reported. (See Table 13)

Table 13 Types of Abuse/Neglect*

	Worcester % (n=62)	Boston % (n=65)
Some physical abuse sustained	43.5	64.7
Some pyschological abuse sustained	82.2	83.1
Some material abuse sustained	56.4	46.1
Some neglect sustained	56.4	58.5

* The data presented in this Table are based on the specific manifestations of abuse/neglect shown in Table 2.

Because the intentionality of neglect was not specified in the question requesting details about its nature, the categories of passive and active neglect have been collapsed into one group of general neglect. These data show that physical abuse occurred at a similar frequency as material abuse and neglect. In Boston some physical abuse occurred in 32 (64.7 percent) cases; material abuse was noted in 30 (64.1 percent); and neglect was found in 38 (58.5 percent). For Worcester, there were 27 (43.5 percent) cases of physical abuse; 35 (56.5 percent) cases of material abuse; and 35 (56.5 percent) cases of neglect. Not suprisingly, psychological abuse, a likely corollary of other forms of abuse and neglect, was found in four-fifths of the cases at both sites.

Extent of Abuse/Neglect (Table 14)

The extent of abuse/neglect sustained by elderly clients is reflected by the severity of the specific manifestations (see Table 2) and the regularity of its occurrence. Bruises and welts were, by far, the most common form of physical abuse occurring in 70.4 percent of such cases in Worcester and 50.0 percent in Boston. Verbal assault, threats, and intimidation represent a similar dimension of psychological abuse which was found in more than half of the cases of this type of abuse. Other common types of psychological abuse include humiliation and the isolation of the elder. The taking or misuse of money or property belonging to the elder client were the usual types of material abuse, noted in more than half of the cases at each site. The most typical form of neglect was the domestic caretaker's failure to provide support and companionship to the older person, reported for approximately two-thirds of the cases of neglect at both sites. Other kinds of neglect, related to requirements of daily living, were the failure to help the elder with personal hygiene, food purchasing and preparation (noted in almost half of the cases of neglect), and housecleaning.

The severity of abuse/neglect cases is illustrated in Table 14 which shows that nearly two-thirds of all cases at each site occurred on a regular basis.

Table 14 Regularity of Abuse/Neglect

	Worcester % (n=62)	Boston % (n=65)
Once or twice	8.9	9.5
A few times	31.1	23.8
Regularly	60.0	66.7
Not answered	(17)	(23)

*Percentages are based on the number of cases for which data were reported

Profile of Abused/Neglected Elderly

Sociodemographic characteristics (Table 15). Of the abused and neglected elderly in the sample, nearly three-quarters were women. For 65.2 percent of the cases in Worcester and 73.9 percent in Boston, the annual income of these aged clients was less than $5,000. Almost four out of five cases in both sites involve elderly who are without partners of the opposite sex because of death, divorce or choice. In Worcester, all but one victim was white, whereas in Boston, 29.2 percent of the group was black. The ages of the abused elders in the two cities show no discernable pattern except that Boston has half of its cases over 75 years compared to only one-third of Worcester clients.

Living situation of abused/neglected clients (Table 16). Two-thirds of the elderly in both Boston and Worcester lived with other people, usually including a relative. In over half of the cases in the two cities, the elderly victims lived with the perpetrator of the abuse or neglect. Of

Table 15 Sociodemographic Characteristics of Abused/Neglected Elders

	Worcester	Boston
	% (n=62)	% (n=65)
Sex:		
Male	22.6	21.5
Female	77.4	78.5
Approximate annual income		
$ 4,999 or less	65.2	73.9
5,000 - $ 9,999	30.4	26.1
10,000 - 14,999	4.3	-
15,000 - 19,999	-	-
20,000 and over	-	-
No answer	(16)	(42)
Marital status:		
Single	8.1	24.2
Married	14.5	21.0
Divorced/separated	14.5	3.2
Widow/widower	62.9	51.6
No answer		(3)
Religion:		
Catholic	57.9	56.1
Protestant	28.9	34.1
Jewish	5.3	7.3
None	5.3	-
Other	2.6	2.5
No answer	(24)	(24)
Race:		
Native American	-	1.5
Black	-	29.2
Latino/Latina	1.6	6.2
Asian	-	-
White	98.4	61.5
Other	-	1.5
Age at initial reporting:		
Under 60	4.8	4.6
60 - 64	24.2	12.3
65 - 69	6.5	23.1
70 - 74	32.3	10.8
75 - 79	14.5	10.8
80 - 84	8.1	26.2
85+	9.7	12.3

*Percentages are based on the number of cases for which data were reported.

Table 16 Living Situation of Abused/Neglected Elders

	Worcester	Boston
	%	%
	(n=62)	(n=65)
Does the abused/neglected elder live with others?		
Yes	66.1	70.8
No	33.9	29.2
If YES, who resides at the same address as the abused/neglected elder?		
Spouse	24.4	27.3
Children	65.8	59.1
Siblings	17.1	6.8
Other relatives	48.8	36.4
Non-relatives	12.2	27.3
No answer	(21)	(21)
If YES, what is the approximate annual income of the household?		
$ 4,999 or less	17.2	23.3
5,000 - $ 9,999	62.1	53.3
10,000 - 14,999	10.3	16.7
15,000 - 19,999	3.4	6.7
20,000 and over	6.9	
No answer	(33)	(33)
Does the abuser live with the abused/neglected elder?		
Yes	54.3	66.1
No	39.0	30.6
In and Out	6.8	3.2
No data reported	(3)	(3)
Does the abused/neglected elder have family, friends or relatives outside the household?		
Yes	81.4	85.5
No	18.6	14.5
No answer	(3)	(3)
Are any available to the abused/neglected elder for any kind of assistance?		
Yes	50.9	61.0
No	49.1	39.0
No answer	(5)	(6)

*Percentages are based on the number of cases for which data were reported.

the cases where the relationship of the cohabitant was specified, children were named in approximately two out of three instances. Despite the potential for additional income, the elderly victims still found themselves living in relatively poor households, with three-quarters of the cases, for whom data were reported, living in households with a combined income of less than $10,000.

In four out of five cases in both cities, the abused elders had family or friends living outside the household. Fifty-one percent (50.9) of this pool of potential outside support in Worcester was available to provide some assistance to the elder person. The figure was a little higher in Boston, with 61.0 percent of the potential support network being available to provide help.

Functional status of abused/neglected elders (see Table 17). Seventy-two (71.9) percent of the cases in Worcester and 81.3 percent in Boston had physical or mental disabilities which prevented them from doing routine activities of daily living, e.g., personal hygiene, food preparation, etc. Three-fifths of the Worcester group and nearly three quarters of the Boston cases had some kind of physical impairment. Problems related to mobility, personal hygiene and food preparation were listed most frequently. Forty-percent (40.3) of the Worcester clientele and 55.4 percent of the Boston elders suffered from some form of mental impairment. Confusion/disorientation occurred in nearly half of the Worcester clients and approximately one-third of the Boston elders in which specific data were reported. Other types of mental impairment noted, included depression or anxiety, organic brain syndrome and memory loss.

Table 17 Functional Status of Abused/Neglected Elder

	Worcester % (n=62)	Boston % (n=65)
Does the elder have a physical or mental disability which prevents him or her from meeting daily needs?		
Yes	71.9	81.3
No	28.1	18.8
No answer	(5)	(1)
Physical impairment		
Some physical impairment	60.0	73.8
Cannot take own medicine	18.9	27.1
Generally bedridden	18.9	18.8
Housebound	43.2	39.6
Difficulty with ambulation	54.0	79.2
Cannot perform basic personal hygiene w/out help	59.4	64.6
Cannot prepare own food	43.2	60.4
Other	24.3	29.2
No answer	(25)	(17)
Mental impairment:		
Some mental impairment	40.3	55.4
Organic brain syndrome	-	16.7
Memory loss	8.0	11.1
Confused, disoriented	48.0	30.6
Paranoia	8.0	5.6
Depression, anxiety, mood swings	20.0	11.1
Impaired judgement	4.0	-
Alcoholism	8.0	-
Impairment, non-specific	4.0	41.7
No answer	(37)	(29)

*Percentages are based on the number of cases for which data were reported.

Profile of the Abuser

Sociodemographic characteristics (Table 18). Nearly three-quarters of the perpetrators at each site were under 60 years of age. Their race and religion paralleled those of the elder client. According to the Worcester reports, 71.7 percent of the perpetrators were men, whereas for Boston, 54.0 percent were males. In one out of two cases at each site, the perpetrator was a child of the abuse/neglected person, with people unrelated constituting the next most frequent group of abusers, nearly one-fifth of the cases.

Abuser's history concerning violence and abuse. Except in a few cases, the community agencies did not have knowledge of prior acts of abuse or violence by the perpetrator. Similarly, very little information was available concerning any unusual aspects of the perpetrator's family background, including any abuse or neglect sustained by that person during childhood.

Table 18 Sociodemographic Characteristics of the Abusers

	Worcester	Boston
	% (n=62)	% (n=65)
Age at time of initial reporting:		
10 - 19	3.6	3.4
20 - 29	14.5	5.1
30 - 39	12.7	11.9
40 - 49	21.8	16.9
50 - 59	23.6	35.6
60 - 69	16.4	13.6
70 - 79	3.6	6.8
Over 80	3.6	6.8
No answer	(7)	(6)
Race		
Native American	-	-
Black	1.7	32.8
Latino/Latina	1.7	6.3
Asian	-	-
White	96.6	59.4
Other	-	1.6
No answer	(3)	(1)
Religion		
Catholic	55.2	52.8
Protestant	27.6	33.3
Jewish	6.9	11.1
None	6.9	2.8
No answer	(33)	(29)
Sex		
Male	71.7	54.0
Female	28.3	46.0
No answer	(2)	(2)
Relation of abuser to abused		
Husband	8.5	6.3
Wife	1.7	4.8
Son	37.3	33.3
Daughter	20.3	17.5
Sister	3.4	3.2
Brother-in-law	-	1.6
Daughter-in-law	6.8	3.2
Other relative	15.3	11.1
Non-relative	16.9	22.2
No answer	(3)	(2)

*Percentages are based on the number of cases for which data was reported.

Problems experienced by abusers (Table 19). A history of mental illness was reported for one-third of the perpetrators in both the Worcester and Boston surveys. In two out of five cases at both sites the person responsible for the abuse/neglect was experiencing problems with alcohol or drugs. Medical complaints, financial difficulties and recent losses (i.e., loss of spouse through death or divorce, death in the family, loss of job, etc.) were found to be problems experienced by perpetrators in at least 20 percent of the cases in each locality.

Table 19 Problems Experienced by Abusers

Problems	Worcester % (n=62)	Boston % (n=65)
Alcohol and/or drug abuse	43.8	43.1
History of mental illness	31.2	31.4
Long term medical complaint	10.4	29.4
Recent medical complaint	10.4	11.8
Long-term financial difficulties	22.9	11.8
Recent financial problems	10.4	13.7
Recent loss of spouse through death/divorce	4.2	15.7
Recent death in immediate family	14.6	7.8
Recent loss of job	8.4	5.9
Past suicide attempt	2.1	3.9
Limited education	14.6	21.6
Lack of needed services	8.4	7.8
Other	20.8	29.4
Not answered	(14)	(14)

*Percentages are based on the number of cases for which data were reported.

Interdependencies between abuser and elder abused/neglected elder (Table 20). For two-thirds of the cases in both Worcester and Boston, the abuser was reported as dependent on the abused for finances. The elder victim was dependent on the perpetrator for companionship in two out of three cases, and for activities of daily living in half of the cases reported in both cities. Given these dependencies, it was not unusual to

Table 20 Interdependencies Between Abusers and Abused/Neglected Elders

	Worcester	Boston
	%	%
	(n=62)	(n=65)
To what degree is the abuser financially dependent on the abused person?		
Independent	31.1	31.4
Slightly dependent	35.6	33.3
Very dependent	33.3	35.3
No answer	(15)	(14)
In what ways is the abused person dependent on the abuser and/or his/her family?		
Finances	35.4	30.9
Companionship	62.5	70.9
Transportation	22.9	21.8
Daily needs	56.3	63.6
Other	22.9	32.7
No answer	(14)	(10)
Was the abused elder a source of stress to the abuser?		
Yes	64.1	72.2
No	35.9	27.8
No answer	(23)	(11)
If YES, in what ways was the abused person a source of stress?		
Interpersonal problems	33.3	14.3
Daily needs	62.5	85.7
Emotional	8.3	2.9
Uncooperativeness	8.3	2.9
Self defense		
No answer or no above to above question	(38)	(30)

*Percentages are based on the number of cases for which data were reported.

find that in nearly two thirds of the cases at both sites, abused person was said to be a source of stress, with daily needs again being emphasized in those cases in which details were provided.

Characteristics of Services Provided to Abused/Neglected Elderly (Tables 21-23)

In just over half of the cases, the abuse/neglect situation was considered resolved at the time of reporting (Table 21). Generally, agencies provided a single service to the elderly client. As indicated in Table 22, reporting agencies offered a range of services to the abused/ neglected persons both on an emergency and long term basis. No one type predominates. The most often reported action was utilization of homemakers, and this help was provided in only one fifth of the cases. In approximately one out of two instances, referrals were to medical and social service agencies while in nearly one-third of all cases, mental health agencies became involved (Table 23).

Table 21 Resolution of the Abuse/Neglect Situation

	Worcester	Boston
	%* (n=62)	%* (n=65)
The situation has been resolved	54.7	54.7
The situation has not been resolved	45.3	45.3
No answer	(9)	(12)

*Percentages are based on cases for which data are reported

Barriers to the Provision of Effective Services

In citing the barriers to the provision of effective services, the reporting agencies provide a diverse list, which includes familial, interpersonal, and resource deficiencies. However, the most often listed cause is the lack of receptivity to help on the part of the victim and the perpetrator. The unwillingness (or inability) of the abused person to receive help was given as the barrier for half of Worcester's cases and for over two-fifths of those in Boston, while lack of receptivity to assistance on

Table 2[2] Services Provided by Reporting Agencies

	Worcester %* (n=62)	Boston %* (n=65)
What action did your agency take in this case?		
Short-term emergency action		
Telephone call to victim	5.4	10.0
Counseling for victim	8.1	2.5
Homemaker-food services	21.6	22.5
Consulted other involved agencies	13.5	12.5
Contact family	2.7	7.5
Encouraged abused to seek help	8.1	-
Contacted perpetrator	5.4	2.5
Hospitalization	8.1	20.0
Evaluation	-	20.0
Removed abused person	13.5	-
Court conviction	2.7	5.0
Crisis intervention program	10.8	-
Lawyer contact, legal services	8.1	8.1
Medication/medical attention	-	5.0
Clothing provided	-	2.7
Nursing/rest home placement	5.4	5.4
Notified field employees	10.8	-
No answer	(25)	(25)
Longer term direct action		
Family intervention	7.9	21.1
Reunited abused with family	-	-
Police protection	2.6	5.3
Legal services, counseling	13.2	2.6
Homemaker services/aides	10.5	10.5
Counseling with abuser	5.3	5.3
Counseling with abused	5.3	7.9
Medical care	5.3	10.5
Changed living arrangements	10.3	15.8
Evaluation	-	2.6
Continued agency involvement	50.0	10.5
Financial assistance	7.9	23.7
Day center services	2.6	2.6
Home care	5.3	-
Nursing home (plans initiated)	-	10.5
No answer	(24)	(27)

*percentages are based on cases for which data were reported.

the part of the abuse was found in over one-third of the Boston cases and more than one-quarter of the Worcester sample.

Table 23 Types of Agencies to Which Abused/Neglected Elderly are Referred

Type	Worcester %* (n=62)	Boston %* (n=65)
Medical facility	56.8	49.0
Mental health agency	31.8	32.7
Social service agency	50.0	46.9
Legal services	15.9	32.7
Home care	11.4	14.3
Police	20.5	-
Other	18.2	34.7
No answer	(18)	(16)

*Percentages are based on cases for which data were reported

Table 24 Barriers to Provision of Effective Services

	Worcester %* (n=62)	Boston %* (n=65)
Barriers to providing effective service		
Lack of cooperation between agencies	9.4	11.6
Ineffective services	3.1	9.3
Poor family relationships	6.3	14.0
Mental impairment of abuser	3.1	7.0
Mental impairment of abused	6.3	7.0
Abused's lack of receptivity to offered services	50.0	41.9
Abuser's lack of receptivity to offered services	28.1	34.9
Dependency of abused on abuser	6.3	-
Abused reluctance to implicate abuser	15.6	7.0
Lack of long term housing options	3.1	-
Financial problems	9.4	9.3
Legal implications	6.3	11.6
Language/cultural barriers	3.1	-
Abused refused to move	3.1	9.3
Lack of respite/emergency shelter	18.8	7.0
No answer	(30)	(22)

*Percentages are based on cases for which data were reported

B. Analysis of Pooled Data from Four Sites

In an attempt to isolate factors associated with different categories of abuse and successful case resolution, chi square analyses was carried out on the pooled sample of all cases from the four sites (Worcester, 62; Boston, 65; Syracuse, 28; and Rhode Island, 22). The two dependent variables in the analyses, i.e., abuse/neglect type and case resolution/non resolution were examined in relationship to the sociodemographic variables, the living situation of the abused, his/her functional status, interdependencies between victim and perpetrator, problems experienced by the abuser, and perceptions of the abuse as potential sources of stress. (The chi-square tables are found in Appendix B, Tables 1-13).

Types of Abuse/Neglect

Sociodemographic characteristics and abuse/neglect type. Neither the age or religion of the abused elder nor the abuser's age, sex, or religion proved to be significantly related, statistically, to the specific types of abuse/ neglect, i.e., physical, psychological and material abuse and general neglect. The rate of occurrence of physical abuse among female victims was significantly higher than the rate for men (p = .039). Fifty seven (57.4 percent) of the 136 women victims were physically abused compared to 39.0 percent of the 41 males. On the other hand, men were more likely than women to be victims of neglect (p = .039). Nearly three-quarters (73.2 percent) of the elderly men were victims of neglect compared a little over half (55.1 percent) of the women.

The marital status of an abused elder was significantly related to the presence or absence of material abuse (p = .05). Specifically, property abuse was much less likely to occur if the elder client was married. There were 35 married abused/neglected elders of whom 9 (or 25.7 percent) were abused materially while the rate for the single, widowed, separated or divorced was, in each instance, slightly above 50.0 percent. Over half (56.5 percent) of all physical abuses were inflicted by adult children. Sons were slightly more likely (31.5 percent) to be the perpetrators than daughters (25.0 percent).

Living situation and abuse type. Physical abuse is much more apt to occur if the perpetrator and victim live together ($p = < .001$). Sixty nine (68.5) percent of the 108 elderly victims living with the perpetrators were physically abused. Of the 55 victims who were not living with the perpetrator, only 29.1 percent were physically abused. On the other hand, material abuse was more likely to occur if a perpetrator did not live with the victim ($p = .002$); 61.8 percent of those who dwelled apart were materially abused compared to 36.1 percent of those who lived together. Psychological abuse and neglect were not significantly related to the presence of the abuser in the abused's household. Both happened at similar rates, whether the perpetrator was present in, or absent from, the victim's household.

As suspected, neglect was more likely to occur if the abused elder did not have friends or family outside the household who were available for assistance ($p = .03$). Of the 70 clients who were without assistance in this form, 71.4 percent were neglected. The availability of outside assistance was not significantly related to the other types of abuse/neglect.

Functional status of the abused/neglected elder. Neglect was evident at a significantly higher rate in those clients who were, to some degree, mentally and or physically impaired compared to those without such disabilities (p=.001). Ninety percent (69.8) of the 129 victims with a physical or mental infirmity were neglected compared to 28.2 percent who did not have such infirmities. Physical or mental impairment was not significantly related to other types of abuse/neglect.

Interdependencies. Physical abuse was more probable when the perpetrator was financially dependent on the victim (p=.025). Among the 123 abusers for whom financial dependency data were reported, physical abuse occurred in 40.5 percent of those who were said to be independent, 70.0 percent of those slightly dependent, and 58.4 percent of those who were very dependent. Financial dependency was significantly related to material abuse (p = .036) although the nature of the relationship is more confusing. Fifty two (52.4) percent of the 42 caretakers who were financially independent of the elder misused or took possession of the property of the elder compared to 63.4 percent of the 41 who were very dependent; yet only 35 percent of the 40 who were slightly dependent victimized the elder in this way.

As Table 25 indicates, the dependency needs of the maltreated older person were more apt to lead to psychological abuse and neglect rather than physical or material abuse. On the whole, each dependency need (i.e., finances, companionship, transportation and daily needs) contributed equally to each type of abuse/neglect. No one dependency need appeared to be a greater stressor within each type of abuse/neglect.

Perception of elder as a stressor. A higher rate of neglect occurred in those cases where the victim was perceived by the agency staff as a source of stress (p = .01). Of those 84 individuals, 77.4 percent were neglected while 55.0 percent of those not perceived as a source of stress were neglected. Material abuse was significantly related to the presence or absence of perceived stress (p=.007). However, in this instance, material abuse happened more frequently if the client was not perceived as a source of stress. Among the 84 clients perceived as stressful, 47.5 percent were materially abused compared to 67.5 percent of the 40 who were not considered to be stressful. This finding would indicate that material abuse is more related to the financial needs of the perpetrator than the dependency requirements of the victim.

Perpetrator problems and types of abuse/neglect. According to Table 26 when a perpetrator is suffering from substance (i.e., alcohol, drugs) problems, mental illness or loss of spouse, he/she is more likely to subject the victim to physical abuse than material abuse or neglect. Of the 56 perpetrators who experienced alcohol/drug problems, 83.9 percent physically abused the elderly in their charge in contrast to 57.1 percent who participated in material abuse and 53.6 percent who neglected them. Similarly, of the 44 with mental illness, 75.0 percent were involved with physical abuse 47.7 percent engaged in material abuse, and 52.3 percent neglected the older person. Among the 31 who had recently lost a spouse, 77.4 percent were involved in physical abuse and 54.8 percent in material abuse or neglect of the older person. On the other hand, abusers with either long term medical or financial problems were more apt to neglect the aged adult. When considering the 44 perpetrators with medical problems 80.0 percent were responsible for neglect compared to 56.8 percent for physical abuse. With respect to the 48 perpetrators with financial problems, 70.8 percent neglected an elder, whereas 45.8 percent were responsible for acts of physical abuse, and 60.4 percent for material abuse. Because psychological abuse is commonly associated with all forms of abuse/neglect, it is not surprising that, irrespective of the type of problem experienced by the perpetrator, psychological abuse is inflicted in four out of five cases.

Table 25 Relationship of Abused/Neglected Persons' Dependencies to Type of Abuse/Neglect

Type of Dependency	Type of Abuse/Neglect*							
	Physical		Material		Psychological		Neglect	
	#	%	#	%	#	%	#	%
Financial n=50	28	(56.0)**	21	(42.0)**	40	(80.0)	37	(74.0)
Companionship n=91	50	(54.9)	41	(45.1)	75	(82.4)	68	(74.7)
Transportation n=40	15	(37.5)	19	(47.5)	33	(82.4)	68	(74.7)
Activities of Daily Living n=90	45	(50.0)	39	(43.3)	72	(80.0)	72	(80.0)

*All percentages use the number of cases with each type of dependence as the denominator.

** $p < .05$

Table 26 Relationship of Perpetrators' Problems to Type of Abuse/Neglect

Type of Problem	Type of Abuse/Neglect*							
	Physical		Material		Psychological		Neglect	
	#	%	#	%	#	%	#	%
Alcohol/drugs n=56	47	(83.9)	48	(85.7)	32	(57.1)	30	(53.6)
Mental illness n=44	33	(65.0)	39	(88.6)	21	(47.7)	23	(52.3)
Loss of spouse n=31	24	(77.4)	26	(93.9)	17	(54.8)	17	(54.8)
Medical complaints n=44	25	(56.8)	39	(88.6)	16	(36.4)	35	(79.5)
Financial problems n=48	22	(45.8)	38	(79.2)	29	(60.4)	34	(70.8)

*All percentages use the number of cases with each type of problem as the denominator

Case Resolution

Chi square analyses indicated that the resolution status of cases of elder abuse/neglect was not significantly related in a statistical sense to the type of abuse/neglect, nor its frequency of occurrence. Successful outcomes were not dependent either on the age, religion, marital status or income of the maltreated elders nor perceptions of them as sources of stress. Whether the abused older person lived with the abuser or not or whether he/she had a social support system did not influence outcome. The health functional status of the older victim was not associated significantly with the resolution of the cases nor were the characteristics of the perpetrator (e.g., age, sex, relationship to the victims and financial dependence. Reported barriers to the provision of effective services with respect to the attributes of the victims, perpetrator or agency delivering care, were also found to be unrelated to the resolution of the abuse/neglect situation.

However, successful outcomes occurred at a significantly higher rate when the elder was male (p=.05); 74.3 percent had their cases resolved successfully compared to 49.1 percent of the female victims. It may be that certain characteristics involving the abuse/neglect of an elderly male may allow cases to be resolved more easily. Finally, case resolution was significantly related to the type of action taken by an agency (p=.0003). Among the seven categories of action (legal, medical, financial, individual counseling, family intervention, home-based services, and environmental change) only the latter, a change in existing living arrangements (e.g., removing perpetrator from household, nursing home placement) which physically separated the abused and abuser had a major impact. Of the 31 cases in which a change in living arrangements took place, 90.3 percent were resolved.

VII. DISCUSSION: INDIVIDUAL CASE REPORTS

The purpose of the Individual Case Reports was to gather data about the nature and extent of elder abuse and neglect. From the descriptive statistics of the Worcester and Boston cases, certain dimensions or common elements have been identified. These are outlined and discussed with reference to the findings of previous research. Some general conclusions concerning the bivariate analyses are also presented.

Seriousness of cases

An examination of the 127 cases of elder abuse/neglect in Massachusetts indicates that perpetrations upon the elderly are severe as to their type and regularity of occurrence. Physical abuse, especially in terms of the infliction of bruises and welts occurred as frequently as material abuse and general neglect. As one might expect, psychological abuse was most common since it often accompanies other forms of abuse/-neglect. The relative frequency of physical abuse compared to other victimizations is a surprising finding since previous research has suggested that physical abuse occurs less than other types of abuse/neglect (Hickey and Douglass, 1981; Sengstock and Barrett, 1981). An additional marker of the seriousness of cases is the finding that in two out of three instances, the abuse/neglect is on-going.

Vulnerability of elder client

As has been shown in previous research, the abused older person's ability with respect to managing their personal care and finances is impaired (Lau and Kosberg, 1979; Legal Research and Services for the

Elderly, 1979; Block and Sinnott, 1979; Rathbone-McCuan, 1980). Most of the elders in this study had a physical or mental impairment which inhibited them from carrying out activities of daily living. Specifically, they were often confused and disoriented or in some cases, suffering from depression, anxiety, memory loss or organic brain syndrome. In addition, limited mobility impaired their ability of many to take care of their personal needs. Physical and or emotional infirmity and a lack of financial security place the elderly person in a vulnerable position and increase the risk of his/her participation in an abuse/neglect situation.

Social and Familial Integration

The majority of elderly victims live without a partner of the opposite sex because of death, divorce or choice and thus may be deprived of what could be called "shared intimacy". Physically, however, the abused elder is not isolated since most live with other people, usually a relative, as has been found in previous research (Lau and Kosberg, 1979). In fact, most often it is with adult children. From one-half to two-thirds of the victims at the two sites lived with the perpetrator, a finding somewhat smaller than reported in the earlier Massachusetts survey, which showed three out of four clients living with the abuser (Legal Research and Services to the Elderly, 1979). Given the above "typical" living situation, plus the existence of friends and family outside the household in the vast majority of cases, half of whom are willing to provide assistance, it appears that elderly persons who are maltreated are not isolated socially. Isolation, if it does exist, within the household may be more emotional depending on the qualitative experience of the social network and the absence of a partner, or the family itself may be isolated.

The Inpaired Perpetrator

The "typical" perpetrator of elder abuse and neglect has been described as middle aged and an offspring, usually a daughter (Pedrick-Cornell and Gelles, 1981; Lau and Kosberg, 1979, Block and Sinnott, 1979). Data from this project indicates that, in fact, men are more likely to be the perpetrators and in one out of two cases, the abuser is an adult child of the victim. These findings are similar to those of Sengstock and Barrett (1981). Previous studies have portrayed a perpetrator of elder abuse and neglect as one who is impaired with respect to mental illness, alcohol or drug problems, medical complaints or financial difficulties (Block and Sinnott, 1979; Rathbone-McCuran, 1980; Legal Research and Services to the Elderly, 1979). Data from the Projects corroborates this picture.

The Web of Mutual Dependency

An abused or neglected client is, in many ways, dependent on the abuser-caretaker, especially for companionship, help with activities of daily living and finances. It is not unusual to learn therefore that the elderly victim is perceived generally as a source of stress to the caretaker by agency staff because of dependency needs. The perception of the abused elder as a source of stress is also supported by prior studies (Legal Research and Services to the Elderly, 1979; Block and Sinnott, 1979; Steinmetz, 1978). Much more surprising is the finding that despite the low reported incomes of the abused clients, in two out of three cases the perpetrator is somewhat dependent on the victim for financial support. The elder victim and perpetrator are thus locked together in a web of mutual interdependency.

The bivariate analysis, although very limited at this stage of the study, does provide further insight into the nature of abuse and neglect. Are there specific characteristics which differentiate between, for instance, a case of physical abuse from psychological abuse? According to these findings, physical abuse is apt to be found in situations where the victim is female and inhabitating the same household with a perpetrator who suffers from substance abuse and/or mental illness and who is financially dependent on the victim. The factor most closely associated with psychological abuse is the dependency of the abused on the abuser for assistance in meeting daily needs. The neglect situation is also related to dependency but includes other features such as a mentally and physically impaired elder, who is a source of stress and for whom there is no outside assistance.

Material abuse appears to be quite a different phenomenon from the three types described above. The perpetrator is financially dependent on the victim, but they are not likely to live together or be married and the victim is not a source of stress. Yet, even with this type of victimization, dependence is a major factor. Again, the analysis confirms the earlier findings that abused and abuser need each other for various physical, emotional and financial reasons. It is not surprising therefore, that the situations are difficult to resolve. In reviewing the significant relationships for each type of abuse, it is apparent that there are factors which distinguish one from the other as well as a common theme of dependency. Further analyses along these lines may not only shed light on

294 the causes but should be helpful in developing prevention and intervention strategies.

Conclusion

A two-part community survey was conducted by the three Model Projects in the latter part of 1981 to determine the nature and extent of elderly abuse and neglect and to gather baseline data for measuring the impact of the Model Project activities. Using responses from 280 agencies in four sites (Worcester area (MA), City of Boston, Onondaga County (NY) and the State of Rhode Island) it was learned that almost all agencies are aware of elder abuse and not reluctant to report it. An attempt to obtain statistics on the number of cases of abuse and neglect, either in total or by type (physical, psychological, material, active and passive neglect), was hampered because of difficulty in identification of cases, confusion between neglect by others and self-neglect, and perhaps the lack of experience on the part of the respondents with the classification system. While there are variations among the three Model Projects in the relative importance given the type of organizations involved in the communities' response systems,the agencies most often called upon for handling abuse and neglect cases, include programs for the elderly, social service agencies, home health organizations, legal services and the police. The most needed resource in all sites was emergency shelter.

Data collected from the Individual Case Reports completed by the community agencies documented the existence of elder abuse and its severity in terms of the multiple manifestations and reoccurrence. Similar to the findings from other studies, the profile of abused in this sample was a white female, seventy years or older, with physical and mental impairments, who was dependent on the abuser-caretaker for help with activities of daily living and companionship. The person responsible for the abuse was usually a relative with a history of mental illness, alcohol or drug abuse, or medical problems and who had become financially dependent on the elder individual. This web of interdependency and disability entrapped both the victim and the perpetrator, making it difficult for them to seek or accept outside help.

Since elder abuse is so intimately tied to the family, theories of family violence provide an appropriate framework for seeking clues to its etiology. While the data gathered during this stage of the Model Projects are too limited in scope and depth for testing the various theories, they do suggest certain causal influences. The high proportion of victims and perpetrators with problems of alcohol or drug abuse and mental illness lends credence to the belief that the cause may be intra-individual in origin. On the other hand, the dependence of elders on their caretakers, which has been well documented in this study, would support a social-psychological explanation, for example, the agression-frustration theory. Also, although there is not enough information yet to determine the role of social learning in predicting abuse, there is a suggestion that unresolved family relationships as well as history of mental illness are important precipitating factors. More data than is available here will be necessary to validate the exchange theory which has been proposed by researchers in family violence. The general finding from this study would tend to contradict it since often the elder victim still has power in terms of supporting financially the son or daughter who has taken on, or been left, with the caretaking function. It is this reciprocal dependency, perhaps pathological, which seems to breed hostility, frustration and abuse. From the evidence in the Individual Case Reports, most families are living in near poverty circumstances, at least in terms of liquid assets, with limited social supports, knowledge, and increasingly stressful situations. Pursuing socio-cultural theories may be the most fruitful approach, if prevention and intervention strategies are the primary objectives of this study.

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The Commonwealth of Massachusetts
University of Massachusetts
Worcester 01605

MEDICAL CENTER
ONTOLOGY PLANNING PROJECT
55 Lake Avenue North

Telephone: (617) 856-3084

Dear

The Greater Worcester Area has been chosen as one of four sites in the country where the problem of elder abuse will be studied and some strategies devised to deal with it. This three-year project, supported by a grant to the Massachusetts Department of Elder Affairs from the Administration on Aging, is designed not only to collect data about the subject, but also to identify services presently dealing with elder abuse, to learn more about how these services may be improved and to develop additional services as needed.

The Survey which is enclosed, and which we earnestly hope that you will complete, attempts to determine the nature and extent of elder abuse in the Worcester area. There will be a follow-up survey annually to see what success, if any, has been achieved in increasing community awareness of elder abuse and in assisting those who are unfortunate enough to be affected.

We realize that this questionnaire is a formidable looking document and that it will take more than a few minutes of your time to complete. However, we hasten to point out that only a few agencies/organizations are involved to the extent that they will be able to fill it out completely. Please try to find the time to answer; it is important that you do so even if your response is that you have encountered no cases during the specified time period. We call your attention to the fact that elder abuse, for the purposes of the project, is restricted to abuse by a caretaker in a domestic setting. Thus, we are excluding institutional abuse and self-inflicted abuse. The definition, by categories, is spelled out in question #10.

Duplicate reporting can be a problem in any survey, particularly when dealing with a relatively small geographic area such as this one. To reduce the possibility and to improve the quality of the date, we have asked those completing the individual case reports to use the letter code.

When this project was proposed, a great many community agencies/organizations took the time to give it their written endorsement and to offer their assistance. We believe that the documentation of the support was a major factor in the receipt of the grant.

If you have any questions about the survey, please call research staff members, Rosalie Wolf at 856-3084 or Michael Godkin, 856-3917. If you wish more information about the Elder Abuse Project, please call the Coordinator, Edward McCarthy at Elder Home Care Services of Worcester, 756-1545. A stamped addressed mailback envelope is attached for your convenience.

Thank you for your cooperation.

Sincerely,

Rosalie S. Wolf, Ph.D.
Gerontology Planning Project
Research Director
Services to Abused Elders Project

RSW:pz

Enc.

ELDER ABUSE/NEGLECT SURVEY

AGENCY REPORT

1. Agency Name ____________________

   Your Job Title ____________________

2. How many elder clients (i.e., 60 years and over) were active cases at your agency between October 1, 1980 and March 31, 1981? ________

3. Please check one of the following:

   The agency staff is aware of elder abuse/neglect but has not encountered specific cases. ________

   The agency staff has known at least one case of elder abuse/neglect. ________

4. How reluctant is the agency to report a case of elder abuse/neglect to an appropriate agency?

   ____ not at all reluctant
   ____ a little reluctant
   ____ very reluctant

5. If you answered "a little" or "very" reluctant to the previous question, please indicate your reasons:

6. Name the agencies that you would think of turning to with cases of elder abuse/neglect (e.g.; VNA, Elder Home Care Services, the Age Center; police, etc.)

7. If you have been involved in elder abuse/neglect cases, name the agencies you have turned to in the past for help.

8. If you have been involved in elder abuse/neglect cases list any services which you think are needed for their effective resolution, but which are presently unavailable.

9. Does your agency have a procedure for dealing with suspected cases of elder abuse/neglect?

___ Yes
___ No

If YES, describe the procedure or attach a copy.

If NO, how do you handle a suspected elder abuse/neglect case?

10. Using the following categories, please specify the number of cases (definite or highly suspicious) of domestic, elder abuse/neglect which were reported to you or with which you have been involved, during the time period October 1, 1980 to March 31, 1981 (include cases that were first reported prior to October 1, 1980 if you were still actively involved with them during the above time period).

10. (continued)

ABUSE:

physical -	the infliction of physical pain or injury, physical coercion (confinement against one's will) e.g., slapped, bruised, sexually molested, cut, burned, physically restrained, etc.
psychological -	the infliction of mental anguish, e.g., called names, treated as a child, frightened, humiliated, intimidated, threatened, isolated, etc.
material -	the illegal or improper exploitation and/or use of funds or other resources

NEGLECT:

active -	refusal or failure to fulfill a caretaking obligation, INCLUDING a conscious and intentional attempt to inflict physical or emotional distress on the elder e.g., deliberate abandonment or deliberate denial of food or health-related services
passive -	refusal or failure to fulfill a caretaking obligation, EXCLUDING a conscious and intentional attempt to inflict physical or emotional distress on the elder e.g., abandonment, non provision of food, or health-related services because of inadequate knowledge, laziness, infirmity or disputing the value of prescribed service

NUMBER OF CASES OF ABUSE/NEGLECT ____________________

11. Using the following definition, please specify as best you can the number of cases of self abuse/neglect (definite or highly suspicious) with which your agency has been involved during the time period October 1, 1980 to March 31, 1981.

    Self neglect refers to an elder, often living alone, who plays a role in his/her own deterioration or demise, usually because of mental deterioration or physical incapacity.

Number of cases of self neglect ____________

INDIVIDUAL CASE REPORT

ELDER ABUSE/NEGLECT SURVEY

Please complete the following form for each case (definite or highly suspicious)of domestic elder abuse/neglect, excluding self abuse/neglect, which has been handled by the agency during the period 10/1/80 - 3/31/81. i.e., only those clients who can be classified by the categories in Q 10.

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12. To enable us to identify a client who is/was treated by more than one agency, please write in the name code for the abused/neglected person.

1st letter of first name	1st and 2nd letters of last name
☐	☐☐

13. a. What was the date when your agency first became involved with this client as a case of abuse/neglect?

Year _____ Month ________ Day ________

b. Is your agency still involved with this client as a case of abuse/neglect?

Still involved ________; Involvement terminated on:
Year _______ Month _______ Day _______

14. To enable us to determine whether this client lives in the appropriate service area, please indicate the city/town and zip code in which this client lives.

15. Using the classification scheme in question 10, please indicate the nature of this particular abuse/neglect case, e.g., psychological abuse, passive neglect, etc. (use more than one category if appropriate).

16. How soon after the initial incident of abuse/neglect was the case discovered by, or reported to your agency?

____ within a month
____ between one month and one year
____ longer than a year
____ unknown

17. Who brought this case to the agency's attention?

____ personal observation
____ client (self report)
____ member of client's family
____ hospital or clinic
____ police
____ private physician
____ lawyer/paralegal
____ client's friend or neighbor

____ private agency
specify: ____________________
____ public agency
specify: ____________________
____ co-worker
job title: ____________________
____ other
specify: ____________________

____ unknown

18. How often was the client abused/neglected?

____ once or twice
____ a few times
____ regularly
____ unknown

INFORMATION ON CLIENT (ABUSED/NEGLECTED PERSON)

19. Client's age at time of initial reporting:

____ under 60
____ 60-64
____ 65-69
____ 70-74

____ 75-79
____ 80-84
____ 85 and over
____ unknown

20. Race:

____ Native American
____ Black
____ Latino/Latina
____ Asian
____ White
____ Other (specify): ____________________
____ Unknown

21. Religion:

____ Catholic
____ Protestant
____ Jewish
____ None
____ Unknown
____ Other (specify): ____________________

22. Sex:

____ Male
____ Female
____ Unknown

23. Marital status:

____ Single
____ Married
____ Divorced/separated
____ Widow/widower

24. Does the subject live with others:

____ Yes
____ No

25. a. If YES, who resides at the same address as the client:

	Relationship	Age	Sex
1.			
2.			
3.			
4.			
5.			

b. If YES, what is the approximate annual income of the household in which the client lives?

____ $4,999 or less
____ $5,000 - $9,999
____ $10,000 - $14,999
____ $15,000 - $19,999
____ $20,000 and over
____ Unknown

26. What is the approximate annual income of the client?

____ $4,999 or less
____ $5,000 - $9,999
____ $10,000 - $14,999
____ $15,000 - $19,999
____ $20,000 and over
____ Unknown

27. Does the client have family, friends or relatives outside the household?

____ Yes
____ No
____ Unknown

Are any available to the client for any kind of assistance?

____ Yes
____ No
____ Unknown

28. Does the client have a physical or mental disability which prevents him or her from meeting daily needs?

____ Yes
____ No
____ Unknown

29. Physical Impairment (check all that apply):

____ none apparent
____ generally bedridden
____ house-bound
____ difficulty with ambulation
____ cannot perform basic personal hygiene w/out help (bathing, toileting)
____ cannot prepare own food
____ cannot take own medication
____ other, please specify:
____
____ unknown

30. Mental Impairment:

____ Yes
____ No
____ Unknown

Evidence of mental impairment: ____

INFORMATION ON ABUSES

31. Physical abuse sustained (check all that apply):

____ none apparent
____ bruises, welts
____ sprains, dislocations
____ malnutrition
____ burns, scalding
____ abrasions, lacerations
____ wounds, cuts, punctures
____ internal injuries
____ dismemberment
____ sexually molested
____ oversedation
____ hypothermia (subnormal body temp.)
____ bone fractures
____ skull fractures
____ direct beatings
____ forced into nursing home
____ tied to bed
____ tied to chair
____ other physical confinement against will
specify: ____________________
____ other (describe): ____________________
____
____
____ unknown

32. Psychological abuse sustained (check all that apply):

____ verbal assault
____ threat
____ intimidation
____ humiliation
____ isolation
____ other (specify): ____________________

____

____ unknown

33. Material abuse sustained (check all that apply):

____ taking possession of money or property of abused/neglected
____ misuse of money or property of abused/neglected
____ other (specify): ____________________

____

____ unknown

34. Neglect sustained (check all that apply). Consider only neglect related to non-professional caretaker's failure to fulfill obligations.

____ abandoned
____ lack of help house cleaning
____ lack of food
____ lack of heat
____ lack of personal care (e.g., bathing, toileting)
____ lack of supervision generally
____ lack of support/companionship
____ lack of heat
____ failure to purchase prescribed medications
____ no false teeth when needed
____ no hearing aid when needed
____ no glasses when needed
____ failure to provide other prescribed medical services
specify: ____________________

____ failure to fulfill other caretaking obligations
specify: ____________________

____ unknown

INFORMATION ON ABUSER/NEGLECTOR (i.e., perpetrator)

35. Age at time of initial reporting:

____ 10-19
____ 20-29
____ 30-39
____ 40-49
____ 50-59
____ 60-69
____ 70-79
____ over 80
____ unknown

36. Race:

____ Native American
____ Black
____ Latino/Latina
____ Asian
____ White
____ Other (specify): ____________________

____ Unknown

37. Religion:

____ Catholic
____ Protestant
____ Jewish
____ None
____ Unknown
____ Other (specify): ____________________

38. Sex:

____ Male
____ Female
____ Unknown

39. Relation of abuser to client:

____ husband
____ wife
____ son
____ daughter
____ sister
____ brother
____ sister-in-law
____ brother-in-law

____ son-in-law
____ daughter-in-law
____ other relative (specify):

____

____ non-relative (specify):

____

____ unknown

40. Does the abuser live with the client:

____ Yes
____ No
____ Unknown

41. Was the abuser experiencing any of the following (check all that apply):

____ alcohol and/or drug abuse
____ long-term medical complaint (self or family)
____ recent medical complaint (self or family)
____ recent loss of spouse through death or divorce
____ recent birth of child
____ recent death in immediate family
____ past suicide attempt
____ long-term financial problems
____ recent financial problems other than loss of job
____ recent loss of job
____ limited education
____ history of mental illness
____ lack of needed services (self or family)
____ other (specify): ____

____

____

42. To what degree is the perpetrator financially dependent on the abused/neglected person?

____ independent
____ slightly dependent
____ very dependent
____ unknown

43. In what ways is the abused/neglected person dependent on the abuser and/or his/her family (check all that apply)?

____ finances
____ companionship
____ transportation
____ daily needs (e.g., meals, medications)
____ other (specify): ______________________________

____

____ unknown

44. a. Perpetrator's stated reason for abuse/neglect:

b. Clinically assessed reason for abuse/neglect:

312 45. Was the elderly client a source of stress to the abuser?

____ Yes
____ No
____ Unknown

46. If YES, in what ways was the client a source of stress (e.g., caretaking obligations like food preparation, personal care or medication administration, financial dependency)?

47. Has the perpetrator ever been responsible for additional acts of abuse/neglect to others (check all that apply)?

____ child abuse
____ spouse abuse
____ documented assault and/or battery on others
____ other (specify): ______________________________
____

____ unknown

48. Was the perpetrator abused or neglected as a child?

____ Yes
____ No
____ Unknown

49. If you answered YES to question 48, please elaborate and specify the relationship of the person responsible:

50. Did the abuser come from an unstable or untraditional background (e.g., single-parent upbringing, non-parental unbringing, violence or abuse in the home, etc.)?

____ Yes
____ No
____ Unknown

If you answered YES to this question, please elaborate:

ACTION TAKEN

51. What action did your agency take in this case?

____ short term/emergency action (specify): ____________________

____

____

____ longer term direct action (specify): ____________________

____

____

____ referral to (check all that apply):

  ____ medical facility (specify): ____________________

  ____

  ____ mental health agency (specify): ____________________

  ____

  ____ social service agency (specify): ____________________

  ____

  ____ legal services agency (specify): ____________________

  ____

  ____ police

  ____ other (specify): ____________________

  ____

  ____ unknown

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52. Other than the agencies to which you may have made a referral, please list other agencies which you know to be involved in this case:

53. Specify any barriers to the provision of effective services in this case (e.g., the number of services involved in the case, a lack of cooperation between agencies, a lack of receptivity to help by the client or perpetrator, reimbursement, legal implications of intervention, lack of respite facilities, temporary shelters and protective services, etc.):

54. Has the abuse/neglect situation been resolved?

____ Yes
____ No
____ Unknown

In what way has it (not) been resolved:

55. Job title of person completing individual case report:

56. Date of completion of this case report:

Year _____ Month _____ Day _____

****

THANK YOU FOR YOUR HELP.

TRAINING NEEDS ASSESSMENT

a. Would the staff of your agency be interested in more training about elder abuse/neglect? _____Yes _____No

b. If training were made available, what group from your agency should be included?

____direct care/service providers
____outreach workers
____supervisors
____administrators
____volunteers
____consumers
____others (please specify) ____________________

____

c. What topics would be of interest?

____overview of abuse
____summary of research findings
____theories of abuse
____potential causes of abuse
____local resources
____service models
____intake and referral processes
____investigation and intervention
____case studies
____legal fundamentals
____conservatorship-guardianship
____domestic violence
____prevention strategies
____mandatory reporting legislation
____other (please specify) _________________________

____

____

d. What method of training would be most suitable?

____all day program - multidisciplinary
____half day program - multidisciplinary
____half day program - on specific topics
____workshop for supervisors
____inservice education for agency personnel
____seminar series
____short term course in skill development
____other (please specify) ____________________________

____

Table B-1 Physical Abuse X Sex

		PHYSICAL ABUSE			
		No	Yes		
SEX	Male	25 (61.0)	16 (39.0)	41 (23.2)	p=.0395
	Female	58 (42.6)	78 (57.4)	136 (76.8)	
		83 (46.9)	94 (53.1)	177 (100)	

Table B-2 Neglect X Sex

		NEGLECT			
		No	Yes		
SEX	Male	11 (26.8)	30 (73.2)	41 (23.2)	p=.0395
	Female	61 (44.9)	75 (55.1)	136 (76.8)	
		72 (40.7)	105 (58.3)	177 (100)	

Table B-3 Material Abuse X Marital Status

		MATERIAL ABUSE			
		No	Yes		
MARITAL STATUS	Single	11 (45.8)	13 (54.2)	24 (14.6)	p=.05
	Married	26 (74.3)	9 (25.7)	35 (21.2)	
	Divorced/ Separated	5 (41.7)	7 (58.3)	12 (7.3)	
	Widowed	45 (47.9)	49 (52.1)	94 (57.0)	
		87 (58.8)	78 (47.3)	165	

Table B-4 Physical Abuse X Living Arrangements

		PHYSICAL ABUSE No	PHYSICAL ABUSE Yes		
ABUSER LIVES WITH ABUSED	yes	34 (31.5)	74 (68.5)	100 (63.9)	
	no	39 (70.9)	16 (29.1)	55 (32.5)	p= <.001
	periodically	3 (50.0)	3 (50.0)	6 (3.6)	
		76 (45.0)	93 (55.0)	169	

Table B-5 Material Abuse X Living Arrangements

		MATERIAL ABUSE No	MATERIAL ABUSE Yes		
ABUSER LIVES WITH ABUSED	yes	69 (63.9)	39 (36.1)	108 (63.9)	
	no	21 (38.2)	34 (61.8)	55 (32.5)	p= <.001
	periodically		6 (100)	6 (3.6)	
		90 (53.3)	79 (46.7)	169	

Table B-6 Neglect X Assistance Outside the Household

		NEGLECT			
		No	Yes		
PERSONS OUTSIDE HOUSEHOLD AVAILABLE FOR ASSISTANCE	yes	40 (45.5)	48 (54.5)	88 (55.7)	p=.0298
	no	20 (28.6)	50 (71.4)	70 (44.3)	
		60 (38.0)	98 (62.0)	158	

Table B-7 Neglect X Functional Status

		NEGLECT			
		No	Yes		
PHYSICAL AND/OR MENTAL DISABILITY	yes	39 (30.2)	90 (69.8)	129 (76.8)	p = .001
	no	28 (71.8)	11 (28.2)	39 (23.2)	
		67 (39.4)	101 (60.1)	168	

Table B-8 Physical Abuse X Financial Dependency

		PHYSICAL ABUSE			
		No	Yes		
FINANCIAL DEPENDENCY	Independent	25 (59.5)	17 (40.5)	42 (34.1)	
	Slightly dependent	12 (30.0)	28 (70.0)	40 (32.5)	p=.0247
	Very dependent	17 (41.5)	24 (58.5)	41 (33.3)	
		54 (43.9)	69 (56.1)	123	

Table B-9 Material Abuse X Financial Dependency

		MATERIAL ABUSE			
		No	Yes		
FINANCIAL DEPENDENCY	Independent	20 (47.6)	22 (52.4)	42 (34.1)	
	Slightly Dependent	26 (65.0)	14 (35.0)	40 (32.5)	p=.0362
	Very Dependent	15 (36.6)	26 (63.4)	41 (33.3)	
		61 (49.6)	62 (50.4)	123	

Table B-10 Neglect X Source of Stress

		NEGLECT			
		No	Yes		
ABUSED IS A SOURCE OF STRESS TO ABUSER	yes	19 (22.6)	65 (77.4)	84 (67.7)	p = .0109
	no	18 (45.0)	22 (55.0)	40 (32.3)	
		37 (29.8)	87 (70.2)	124	

Table B-11 Material Abuse X Source of Stress

		MATERIAL ABUSE			
		No	Yes		
ABUSED IS A SOURCE OF STRESS TO ABUSER	yes	49 (58.3)	35 (41.7)	84 (67.7)	p=.0072
	no	13 (32.5)	27 (67.5)	40 (32.3)	
		62 (50.0)	62 (50.0)	124	

Table B-12 Case Resolution X Sex

		CASE RESOLUTION		
		No	Yes	
SEX	male	26 (74.3)	9 (25.7)	35 (23.8)
	female	55 (49.1)	57 (50.9)	112 (76.2)
		81 (55.1)	66 (44.9)	147

p = .0089

Table B-13 Case Resolution X Agency Action

		CASE RESOLUTION			
		yes	no		
ACTION TAKEN BY AGENCY	legal services	4 (6.8)	5 (10.9)	9 (8.6)	
	work with family	3 (5.1)	4 (8.7)	7 (6.7)	
	home care	9 (15.3)	13 (28.3)	22 (21.0)	
	medical services	4 (6.8)	8 (17.4)	12 (11.4)	p= <.001
	financial support	6 (10.2)	2 (4.3)	8 (7.6)	
	change in environment	28 (78.5)	3 (6.5)	31 (29.5).	
	counseling	5 (8.5)	11 (23.9)	16 (15.2)	
		59 (56.2)	46 (43.8)	105	

EXHIBIT 2

ORGANIZATIONAL ASSESSMENT OF THE DELIVERY OF PROTECTIVE SERVICES TO ABUSED AND NEGLECTED ELDERS AT TWO MASSACHUSETTS HOME CARE CORPORATIONS

Karl Pillemer
Rosalie S. Wolf

supported by a Title IV-C grant
from the Administration on Aging to the
Massachusetts Department of Elder Affairs

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University Center on Aging
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, MA 01605

I. INTRODUCTION

In the past fifteen to twenty years, interest in the provision of protective services to vulnerable elderly persons has grown. Building on the model used for intervening in child abuse cases, many elderly service agencies have begun outreach to neglected, abused, and abandoned clients. High hopes exist for such programs. One recent manual on improving protective services states their ideal function in the following way:

> It is likely that we would desire the following if we came to depend on strangers [we would add "others"] in time of extreme need; respect for our rights and desires, as much independence as possible, fitting medical treatment, and comfortable personal care. It is to meet these fundamental human needs for people who cannot provide them for themselves that protective services programs have been developed.[1]

In spite of the perceived promise of such programs, little research has as yet been carried out on protective services. A wide variety of different service delivery models exist, the relative effectiveness of which remains unknown. Agencies currently initiating protective services programs do so without the benefit of clear-cut guidelines based on research. Questions which remain to be answered include: What type of agency is most appropriate to sponsor a protective services program? Precisely what services should be offered? Should an agency employ its own specialized workers, or contract with other agencies for protective services? How can linkages with other agencies best be fostered?

It is the purpose of this report to attempt to shed light on questions such as these, by describing and analyzing the approach towards protective services of two Massachusetts Home Care Corporations (HCC). Relying on interviews with staff from each HCC and other community agencies, case reports on protective services clients, and client pathway models, a comparison of the two models will be carried out.

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[1] Improving Protective Services for Older Americans, Vol I: Program Development and Administration. Portland, Me.: Center for Research and Advanced Study, University of Southern Maine, 1982; p. 1.

HCCs appear at first consideration to be ideal sponsors of protective services programs. The twenty-seven Massachusetts HCCs are non-profit corporations which provide home-based social services to eligible persons sixty years of age and older. Funds for the program are provided by the state through the Massachusetts Department of Elder Affairs. In most regions of Massachusetts, HCCs are the central agencies in the elder services network. They provide a large volume of much-needed services, and in most cases are also the location of the Area Agencies on Aging, which gives them an official coordinating role in the area.

Further, the current push towards consolidation and coordination in the human services also supports placing protective services in the HCC. HCCs have direct access to a wide range of social services which can be used to intervene in cases of isolation, abuse, or neglect. Such access, it can be argued, can make the protective services function very powerful. By describing the activities of two HCCs in this area, it is hoped that the apparent promise of HCCs as protective service providers can better be realized.

Although the limitations of this study are detailed in a later section, two cautionary notes should be stated at the outset. First, the current effort is in no way a definitive outcome evaluation; that is, no attempt is made to identify one program as more effective, to the detriment of the other. Such an evaluation would require a much more complex and costly design than this one.

Instead, the organizational analysis presented here is best seen as an extension of the work of Butler-West, et al.[2] This group prepared a comprehensive analysis of different approaches towards protective services by HCCs. The present report details two of the approaches identified in that document, in an effort to ascertain more specifically the positive and negative aspects of each model.

Second, this report will not concern itself with the entire range of protective services. For reasons elaborated upon below, the focus here is on victims of domestic elder abuse and neglect: that is, abuse and neglect perpetrated by others, rather than self-abuse or neglect. In spite of this limitation, we believe that the findings presented here apply in large part to protective services in general.

Finally, many individuals assisted greatly in the completion of this report. Sincere appreciation is extended to the Executive Directors and Staff of Coastline Elderly Services and Elder Services of the Merrimack Valley, and to the many community agency personnel who consented to be interviewed. The assistance of the staff of the Center on Aging at the University of Massachusetts Medical Center is also gratefully acknowledged.

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[2] Butler-West, J., H. Goldsmith, M. Hunter, J. Lurie, and J. Sabol. Capacity Building for Protective Services for the Elderly. Mass. Dept. of Elder Affairs, May, 1982.

II. BACKGROUND

In 1980, the Administration on Aging awarded grants to the Massachusetts Department of Elder Affairs, The Rhode Island Department of Elderly Affairs, and The Metropolitan Commission of Onandaga County, New York to develop and demonstrate viable and replicable strategies for the prevention and treatment of elder abuse. With the involvement of personnel from all three projects, a coordinated evaluation plan was designed, and is currently being carried out by the Center on Aging of The University of Massachusetts Medical Center.

Originally, two sites were selected in Massachusetts for elder abuse model projects: Elder Home Care Services of Worcester, Inc., and the Boston Commission on Affairs of the Elderly. The Boston project was terminated after the first year of operation.

In place of the activities scheduled for the Boston site in the second year of the project, the Massachusetts Department of Elder Affairs (DEA) requested that the Evaluation Team study the way in which two HCCs provide services to abused and neglected elders. One HCC, Elder Services of the Merrimack Valley (ESMV) contracts for protective services with three local Family Service Associations. The other HCC, Coastline Elderly Services (CES) of New Bedford, operates on a more traditional home care model, spreading its abuse/neglect cases among its case managers as they enter the system. However, there has been a history of interest in the problem of abuse/neglect in the New Bedford area, with occasional meetings of an interagency task force on this issue.

In this report, we will describe, compare, and analyze the way in which these two agencies provide protective services to abused and neglected clients. After defining elder abuse/neglect and protective services, and describing the methodology of the study, the report will center on the following questions:

1. What are the major features of each program?
2. What is the history of each program? What unique factors in the service environment influenced its development?
3. How does co-ordination with other agencies take place? How, in dealing with cases of abuse/neglect does each program interact with others in the areas of referrals, service utilization, and management of specific cases?
4. Based on the above information, how replicable are the two models? Are they appropriate only to their unique service environments, or could their basic features be adopted by other agencies interested in providing protective services to abused/neglected elders?

The report concludes with recommendations for further development of protective services in these two HCCs.

What Are Elder Abuse and Neglect?

As noted above, our investigation was confined to abuse and neglect by others; that is, we were not concerned with self-neglect or abuse. The operational definitions of abuse and neglect* adopted for the study reflect this focus. These definitions are presented in Figure 1, in which abuse is divided into three types: physical, psychological, and material. Neglect is divided into two categories: active and passive.

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*These definitions are identical to those developed for the Model Projects on Elder Abuse.

Figure 1: Definitions of Abuse and Neglect

ABUSE:

Physical Abuse:	the infliction of physical pain or injury, physical coercion (confinement against one's will) e.g., slapped bruised, sexually molested, cut, burned, physically restrained, etc.
Psychological Abuse:	the infliction of mental anguish, e.g., called names, treated as a child, frightened, humiliated, intimidated, threatened, isolated, etc.
Material Abuse:	the illegal or improper exploitation and/or use of funds or other resources

NEGLECT:

Active Neglect:	refusal or failure to fulfill a caretaking obligation, INCLUDING a conscious and intentional attempt to inflict physical or emotional distress on the elder; e.g., deliberate abandonment or deliberate denial of food or health-related services
Passive Neglect:	refusal or failure to fulfill a caretaking obligation, EXCLUDING a conscious and intentional attempt to inflict physical or emotional distress on the elder; e.g., abandonment, non-provision of food, or health-related services because of inadequate knowledge, laziness, infirmity or disputing the value of prescribed services

What Are Protective Services?

The Protective Services Task Force of DEA adopted the following definition of protective services:

> ...services which are necessary to prevent, eliminate, and/or remedy the effects of abandonment, abuse, coercion, exploitation, or neglect.

Services provided in such a program may include those which attempt to prevent abuse from occurring; those which support elders in maintaining functional independence; and those which act as surrogates for caregivers.[3]

This definition is clearly quite broad. Such a definition, however, is appropriate for the analysis here, due to the considerable difference between the two programs. Only one of the two HCCs (ESMV) has a program specifically termed "protective services". While CES has no special protective services program, existing staff do in fact act as protective service workers for certain clients. For this reason, our definition must encompass the protective services function, rather than the elements of a distinct program. The remainder of this report is thus concerned with the way in which the protective services function, as defined above, is carried out by ESMV and CES.

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[3] Butler-West, et al., 1982.

III. METHODOLOGY

Two major techniques were employed to collect information for this evaluation. First, in-depth interviews were carried out with staff in the two HCCs, and with selected individuals in other community agencies. The latter interviewees were suggested by HCC personnel as persons they had worked with closely on abuse/neglect cases (a description of interviewees appears in Figure 2; for purposes of confidentiality, they have not been identified). Interviews lasted approximately one hour each, and were tape recorded and transcribed. These interviews constitute the major part of this report.

Figure 2: Persons Interviewed

Elder Services of the Merrimack Valley

- Protective Service Workers (3)
- Family Service Association Directors (1)
- ESMV staff (4)
- Community agency staff (3)

Coastline Elderly Services

- CES staff (4)
- District Attorney's Office (2)
- Hospital staff (2)
- Community Agency staff (3)

Second, both HCCs were asked to develop a "client pathway model". This is a flow-chart that diagrams the path of a typical abuse/neglect client through the agency system. The client pathway model is a highly useful tool in understanding the organizational structure of the protective services program.

There are certain obvious limitations to this methodology. A one-time interview with program staff can only give a superficial picture of their activities. Only a small number of persons in other community agencies could be interviewed, which limits our knowledge of referral patterns and exchange of resources. In addition, direct observation of protective services staff on the job would have provided a more complete picture of their activities. Interviews with clients would also add substantially to our understanding of these programs.

Limitations in time and resources made such a comprehensive evaluation design impossible. In spite of this, we have been able to obtain a substantial amount of information about the programs, which allows us to describe and analyze their major components. While not definitive, the findings presented in this report should assist other HCCs in planning for protective services.

IV. MAJOR FEATURES OF THE TWO PROGRAMS

Butler-West, et. al. identify four administrative models which HCCs have employed for the delivery of protective services. Three of these were termed "internal models," and a fourth described as an "external model". The four models will be briefly described here.[4]

> Internal Model A involves utilization of "generic" case managers for the delivery of protective services. All case managers within the HCC are responsible for the few protective services clients which fall in their caseload. The case protocol and client pathway through the system are the same as that for other home care cases. Supervision and training for dealing with these cases are provided through the existing structure.
>
> Internal Model B identifies certain staff members whose sole responsibility is the management of protective service cases. These "specialized" protective service case managers have training and/or expertise in this area.
>
> Internal Model C is based on a specialized assessment team comprised of professionals with expertise in geriatrics and protective services. After assessment, cases are turned over to the generic case manager, although the team may remain available for consultation.
>
> External Model D does not use intra-agency personnel, but instead involves contracting with another service provider for protective services. HCC staff refer appropriate clients to this provider agency after assessment, or at any point at which they determine that a case requires protective services.

The HCCs considered in this report fit two of these models very closely. CES is a "Model A" program: case managers at that agency are responsible for whatever protective service clients appear in their caseload. They are supervised in protective services work by their regular supervisor. ESMV, on the other hand, is a "Model D" program. Since 1978, ESMV has contracted with Family Service Associations in Lowell, Lawrence, and Haverill to provide protective services. Therefore, the comparison carried out in this report is between the internal generic case manager approach, and the contracting-out model. There are, of course, unique elements of each particular program, which will be detailed here. In the remainder of this section, the major features of the two programs are described and compared.

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[4] See Butler-West, et. al., pp. 37-39 for more detailed descriptions of these models.

Coastline Elderly Services

As noted above, the approach used by CES for cases of elderly abuse/ neglect parallels that used for all other home care clients. For this reason, it is necessary to describe the standard HCC case procedure.[4]

DEA maintains purchase agreements with Home Care Corporations (HCC), many of which are also Area Agencies on Aging. HCCs provide case management and information and referral services directly, and contract for a range of other services, including homemaker, and chore services, transportation, congregate and home-delivered meals, and legal services. The primary protective service function is carried out by the HCC case manager. It is therefore important to review the central components of case management in the HCC.[5] All clients who request HCC services are initially prescreened by intake workers. A standardized intake form is used called the Comprehensive Needs Assessment Procedure (CNAP). Based on this assessment, a plan of care is developed which must be approved by an HCC supervisor.

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[4] Parts of this discussion are based on Ketron, Inc., "Home Care Cost Study." Mass. DEA, April 29, 1982.

[5] For a more detailed presentation, see Mass. Office of State Health Planning, Channeling Long-Term Care Plan, 1981.

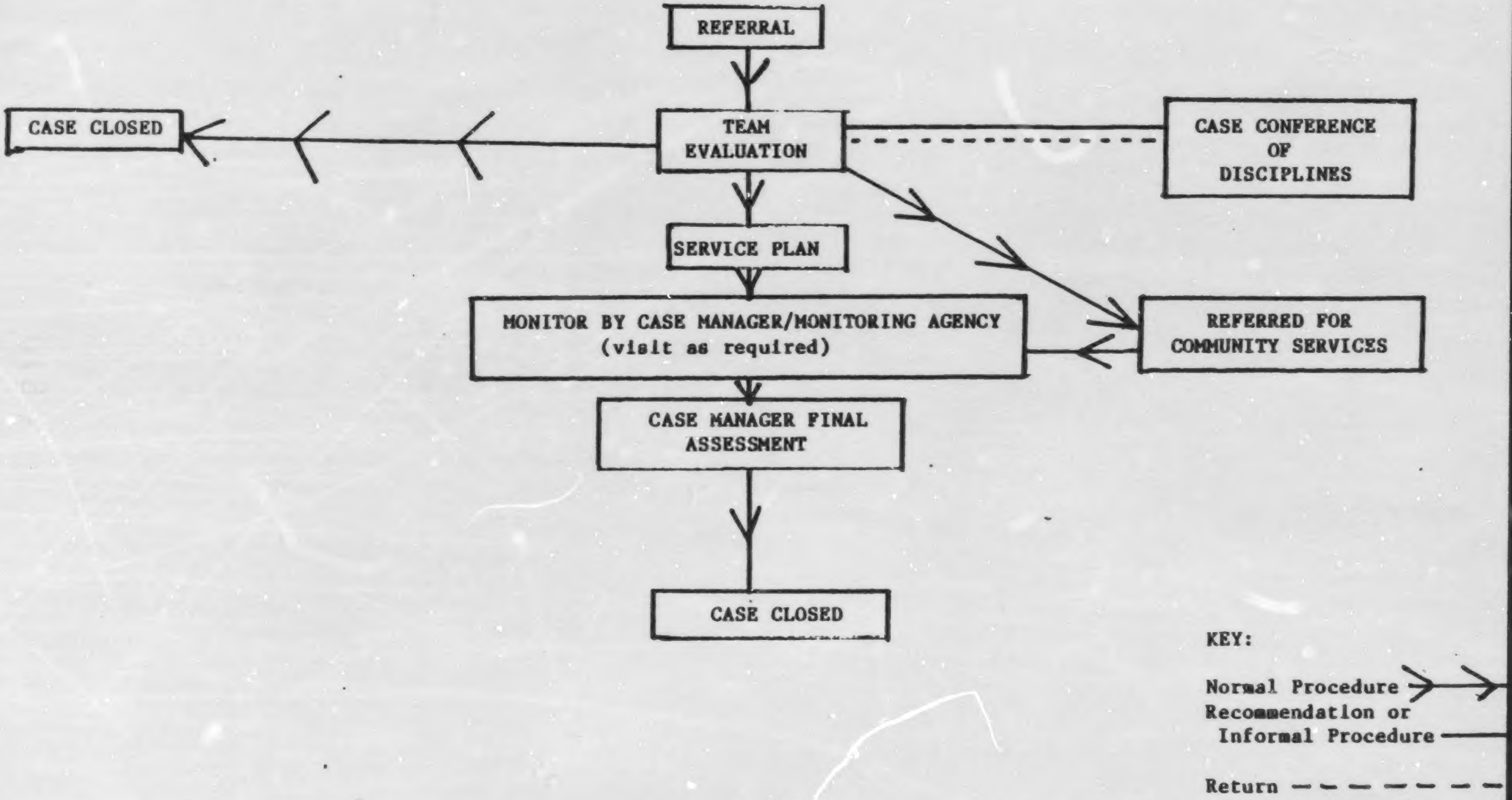
Applicants who are determined to be ineligible for HCC services are assisted by an information and referral specialist in finding another appropriate provider. Clients accepted for service are assigned to a generic case manager, who is responsible for an initial in-home assessment, development of a plan of care, initiation and monitoring of service delivery, and periodic re-assessment of client need.

Clients requiring protective services, who are also eligible for HCC services follow this standard path. They are evaluated at intake, given a service plan, and monitored by a case manager until their case is closed due to death, institutional placement, or lack of need for services. Figure 3 shows the standard case procedure for CES.

A second type of protective services client also exists, however: persons in need of protective services but who do not meet the financial or service eligibility requirements of the HCC. For a number of reasons (described in the following section) an interagency task force designated CES as the key agency in its service area to handle cases of abuse and neglect. CES is routinely contacted by area providers who encounter an actual or suspected case of abuse. Although a number of these cases do not meet eligibility requirements, CES usually attempts an initial intervention.

In general, such abuse/neglect cases are referred by Councils on Aging, Visiting Nurse Associations, St. Luke's Hospital, or occasionally family members or neighbors. Although case managers and supervisors at CES described a few serious cases which required a substantial amount of staff time and effort, the general consensus was that relatively few abuse/neglect cases are referred to CES.

Figure 3: COASTLINE ELDERLY SERVICES CASE PROCEDURE


REFERRAL
CASE CLOSED
TEAM EVALUATION
CASE CONFERENCE OF DISCIPLINES
SERVICE PLAN
MONITOR BY CASE MANAGER/MONITORING AGENCY (visit as required)
REFERRED FOR COMMUNITY SERVICES
CASE MANAGER FINAL ASSESSMENT
CASE CLOSED
KEY:
Normal Procedure
Recommendation or Informal Procedure
Return

When case managers become aware of such a case, they attempt to assess the seriousness of the situation. In consultation with his or her supervisor, the case manager often visits the suspected abuse/neglect client. Often, a case manager will not go out alone on a suspected abuse/neglect case: he or she will be accompanied by a supervisor, another case manager, or staff from another agency involved in the case.

A supervisor at CES described the typical pattern of the initial case contact in the following way:

> I will call the person, based on whatever information I have, and sometimes I don't even let them know, I just say that we're a social service agency, and they were referred to us for some help, maybe homemaking. If its the son or the daughter or a family member that's the abuser and they are in the home, and the chances are that when I call they're there, I will call under the pretense that someone called me for homemaking services, and that they don't have to accept the services, but would they at least allow me to come and visit, and I can explain things further. I kind of insist on it. Generally they let me in. But if the abuser is there, then you just tactfully try to get the questions in, and hope that you get some kind of a response, and hope that they will let you know; nine times out of ten they won't. Usually 5-10 minutes into the questions I kind of know what's going on.
>
> Then I usually leave my name and number and I ask them if there's a problem to call me, and that I'm going to check on them in a few weeks. I will ask the person who told me about the abuse, if its a neighbor, to call me when the person's not there, and I will try to call them back and get some information, when the abused doesn't feel intimidated. Or I will try to get down there before they get back. Sometimes you can do something, but usually they're not receptive, and that is what bothers me the most.

In keeping with the generic case manager model, no staff member has the official function of exclusively dealing with elder abuse/neglect cases. It should be noted, however that a few case managers and supervisors have handled abuse/neglect cases with greater frequency, and have therefore come to occupy an informal role as protective services expert. They are somewhat more likely than other staff to be assigned an abuse case, and much more likely to be consulted about abuse/neglect.

For example, one CES supervisor noted that abuse/neglect cases are often brought to her attention, or that of another supervisor with similar experience in abuse/neglect. She noted:

> [Case managers] know where they can go to get the help they need, and that we can give them some direction. We'll tell them: "You call so-and-so at this office and have them meet you there. We don't feel you should go out alone." Then we give them as much background as we can, what direction they should take.

Thus, although there is no formal elder abuse/neglect specialist on the HCC staff, workers with informal expertise are frequently consulted. The responsibility for the case, however, remains with the case manager. As one supervisor described the process:

> The two people who are available when the call comes in are the ones who go out. There might be a situation where I can't leave the office, so I have to convince two new case managers to go. All I do is tell them what to utilize of you need it, and if they have a problem, to call me. Usually the case manager who has that area goes out, unless she's unavailable. Then it's whoever is in the office that has to go out to that area.

As noted above, CES serves two types of abused/neglected elders: those who are already part of the agency's caseload, and those who are specifically referred to CES for reasons of suspected abuse/neglect. The questions now arise:. What is the nature of the intervention in these cases by CES? What does the agency provide to remedy the abuse/neglect situation?

Both types of cases receive initial assessment and screening by a case manager. Clients already served by the agency have been assigned a case manager earlier; those who are referred for reasons of abuse/neglect are assigned one. Clients already in the system are eligible to receive homemaker and chore services, transportation, legal aid, and to participate in a meals program. The same is true for abused/neglected individuals who are determined to meet HCC eligibility requirements.

These services can be used in such a way as to ameliorate an abuse situation. For example, one case manager was alerted to a physical abuse case by a homemaker. The abuser was occasionally so hostile towards the homemaker that the case manager considered stopping service to the client. She decided against this however, noting that she felt that "this lady needs to be monitored, and if she isn't receptive to services, I'm not going to leave her high and dry, either." She added: "I'm leaving the homemaker in as long as she will go, even if I have to change homemakers every week." Interviews with other CES staff supported this: HCC services are seen as useful in monitoring and altering an abuse situation.

A greater problem is posed by clients who are either ineligible for HCC services, or who are unwilling to accept them. In these cases, the CES case manager will make appropriate referrals to other agencies, and will frequently stay involved in the case on an ad hoc basis until it is resolved.

A final element of the CES approach to elder abuse/neglect is case coordination. Because of the complexity of most elder abuse/neglect cases, and the multi-problem nature of such clients, a number of agencies are likely to be involved with the abused/neglected individual. The CES case manager usually performs a key coordinating role in these instances, by calling interagency case conferences and accepting ultimate responsibility for the client. Although CES has performed this coordinating function for a number of years, it was officially named the primary referral agency for elder abuse in the New Bedford area by an interagency task force in 1980. This designation further strengthened the central role its staff assumes in dealing with elder abuse/neglect. The role of this task force is detailed further in Section V; interagency coordination is discussed in Section VI.

In order to provide a clear picture of the way the protective services function is carried out at CES, two cases are presented here, as told by the interviewees: a case manager, and a case management supervisor. Both examples involve elders who were not at the time clients of CES; for this reason, they are more comparable to ESMV cases.

The first case is one of neglect, which had a successful resolution. As the case management supervisor described it:

> I had received a call from the welfare department. An elderly woman was living with her son who had history of mental illness and had a social worker. His social worker was the one that called saying that they felt the mother was being neglected. She said the son tended to be violent, and could we check it out? She said that the son was unemployed, and likely to be home. So I proceeded to call the woman and ask if I could come down and visit. She was very receptive. I asked if the son would be there, and she said that she didn't know. I was going to meet her in a neighbors apartment. Then I called the police to ask them to meet me there. Should she take me to her apartment and the son be there, and he's not receptive to my being there, at least the presence of a policeman would help.
>
> A case manager and I went out, because we always take another person with us. A police officer met us at the house. The neighbor told us that the mother had gone back downstairs, so we went to her apartment, knocked at the door, and she let us in. The son was not home. The policeman looked through the apartment first, before we did, and then we looked through, and found it was very cold, and there was a dog in a little pen that hadn't been cleaned in days. We called the SPCA immediately, and asked them to pick the dog up, with her permission. We proceeded to get her out of the apartment. We had already contacted her sister, who said that she would take her in. In the process, we asked her different questions that indicated to us that she was abused but that she was trying to cover it up. He would take her check, and not give her the money. He would just take it and blow it. The refrigerator had just two eggs, I think. The apartment was deplorable.
>
> We asked down at the corner store, and they told us that she had gone down there several times, and charged food. They could no longer extend her credit, because the bill was quite high, and they could never get him to come in and pay the bill. We proceeded to tell his social worker what had transpired, and that she had this bill. We said we would try to work with her to pay it up, and then we took her to the sister's house. She wanted to go back home after three days. The son became very belligerent, went to the sister's house and made

> threats. They called and said they didn't feel comfortable. In the interim, we had also made arrangements to have her seen at the mental health clinic. We were taking her there every week for therapy sessions. Our goal was to convince the son that he needed to go for the treatments as well, and eventually he did. That was a successful case in a sense. He is now in his own apartment, and she is in elderly housing. She is still self-sufficient. This took about a year.

Here we have an example of a case which resulted from an external referral, in which the case manager and supervisor were able to intervene. They stayed involved in the case for a year, and arranged for transportation services for the abused. Working on this case was considered to be part of the regular duties of CES staff: no special assistance was provided by the agency, or anyone with specific protective services training. This example is atypical in the involvement of a policeman. Although the police are called in more frequently in CES than ESMV, it is not a common occurrence.

A CES case manager described a less fortunate situation, one in which life-threatening neglect was suspected, but intervention proved impossible.

> We had one case, we received the call late on a Friday afternoon. The call came from a neighbor who lived downstairs from an elderly woman. She said that the woman had fallen down, had refused to go to the hospital and had not come out of her apartment since the day before. She lived with a mentally retarded daughter who was not able to take care of herself; this elderly woman had always taken care of the daughter. The neighbor was concerned, she had not seen either one of them. The woman had fallen on the sidewalk. The police and the ambulance came and brought her back up to the third floor. She said she didn't want to go to the hospital and they left. The neighbor said she did not look all right and she was shaking all over, her tongue was hanging out, and other physical symptoms she gave us. Of course these always come in on Friday afternoons. Two of us went out and tried to get in and there was something obviously wrong with the daughter.
>
> She told us that the woman did not have a fall, she was in bed not feeling good, we do not need your help, go away. We stayed a good fifteen minutes outside the door talking and she wouldn't let us in. I left my card in a box on their door and told her if anything came up to please call me. We then went to the police station to see the report that was filed by the officer the night before, so we talked with them and they had the attitude she is just an old lady. They did say they would send an officer back to the house to meet us there.

> The officer was very cooperative but as soon as he got upstairs he turned from a gentleman to a police officer, real aggressive. The girl would not open the door but we noticed that she had taken the card out of the box. We went back and talked to the supervisor and she said to just let it go. We wanted to contact the clerk of courts but the supervisor said no. Over the weekend the supervisor called the house a few times but the daughter said "We are all right, we do not need your help", and about three days the woman died in her apartment. She was only about 73 years old. I think we could have gotten in there but there was this big fear that we would get a warrant to go in and the woman would be fine - it would have been worth the trouble for the peace of mind.

The outlines of this case are similar to the previous one. The central position of CES as the agency that handles abuse/neglect is clear: it was the agency the neighbor turned to. The case manager who was available at the time attempted to intervene in the case, with no formal assistance from a protective services specialist. It is, of course, impossible to ascertain whether the involvement of a specialized protective services worker would have made the intervention more successful. In a later section, we will consider that possibility more thoroughly.

Elder Services of the Merrimack Valley

In 1978, three Family Service Associations in the Merrimack Valley developed a protective services project under contract to ESMV. They now have over four years of experience working with elderly protective service clients in the area. As noted above, this program fits "External Model D:" that is, it is a contracted-out protective services program, funded by ESMV. The contract is administered by the Family Services Association of Greater Lawrence.

The joint protective services program has five general objectives:

1. To maintain and strengthen the network of services in the Merrimack Valley which serve the frail elderly in danger of abuse, neglect and exploitation.

2. To use clinical social work knowledge and skills and to draw on the expertise of other professionals, to formulate a physical and psychological evaluation to develop a plan of intervention and to implement the plan of care for the individual elderly client at risk.

3. To document on a case-by-case basis the areas of unmet need, to aid in the development of new services, or different use of existing services in order to provide a comprehensive network of services for protective cases.

4. To make a special effort to respond to the needs of low income and minority elderly referred for protective care.

5. To advocate for the need of legislation at a state level to mandate reporting of abuse and neglect of elders and to institute and fund a program of response statewide for those elders in need of protective action.

As should be clear from these objectives, the program does not limit itself to abuse and neglect by others, but also by the clients themselves. In our interviews, however, an attempt was made to confine the discussion to abuse and neglect by others.

This program has a number of distinctive features, which reflect underlying assumptions regarding the function of protective services. First, the program is predicated on the notion that specialized training in social work is a necessary qualification for dealing with abused/neglected clients: all three workers have master's degrees in social work. This perspective was clearly expressed by the administrator of one of the Family Service Associations, who has worked closely with the protective services worker:

> [My point of view is to use] the social worker as the key person in protective services. The social worker is enough of a generalist to know enough about social, psychological, and physical situations. In all three areas, a social worker is trained to recognize his or her own shortcomings, so that when an expert is needed, you draw on the expert's knowledge. In our work with families and family relationships, the social worker's point of view is helpful.

Second, the location of the protective services workers in Family Service Associations indicated a belief that attention to family dynamics is critical to resolving cases of abuse/neglect. As one of the protective services workers described his role:

> My primary [concern] is the agency's [concern], and that is the family. When I look at a situation, I tend to see the family and the family network. I tend to tune in to that more easily, so my consulting [with other agencies] probably has that tone. I look at the situation historically and try to see the person now and learn how he got there.

A third basic assumption is that locally-based workers will be more effective in delivering protective services than those in a centralized agency. Local workers are presumed to have a detailed knowledge of their areas, which is useful in assisting an abused/neglected client in using the service system.

A fourth feature of the program is that it employs part-time workers. At present, the protective service workers are employed 17, 18, and 26 1/2 hours each week, respectively. This limitation on the workers' time has caused a certain amount of dissatisfaction among persons who utilize the protective service workers (see Section VII).

The major activities of the protective services workers can be best described in reference to the client pathway model developed by program staff (Figure 4). This is, to be sure, an ideal model, which corresponds only in part to actual practice. It does, however, provide an overview of the principle features of each program. The client pathway model appears in Figure 4.

Referrals are made to the protective services workers by ESMV, a variety of other community agencies, and family and friends of the abused/neglected individual. The protective services worker makes an initial determination as to whether his or her involvement is justified in the case. If such

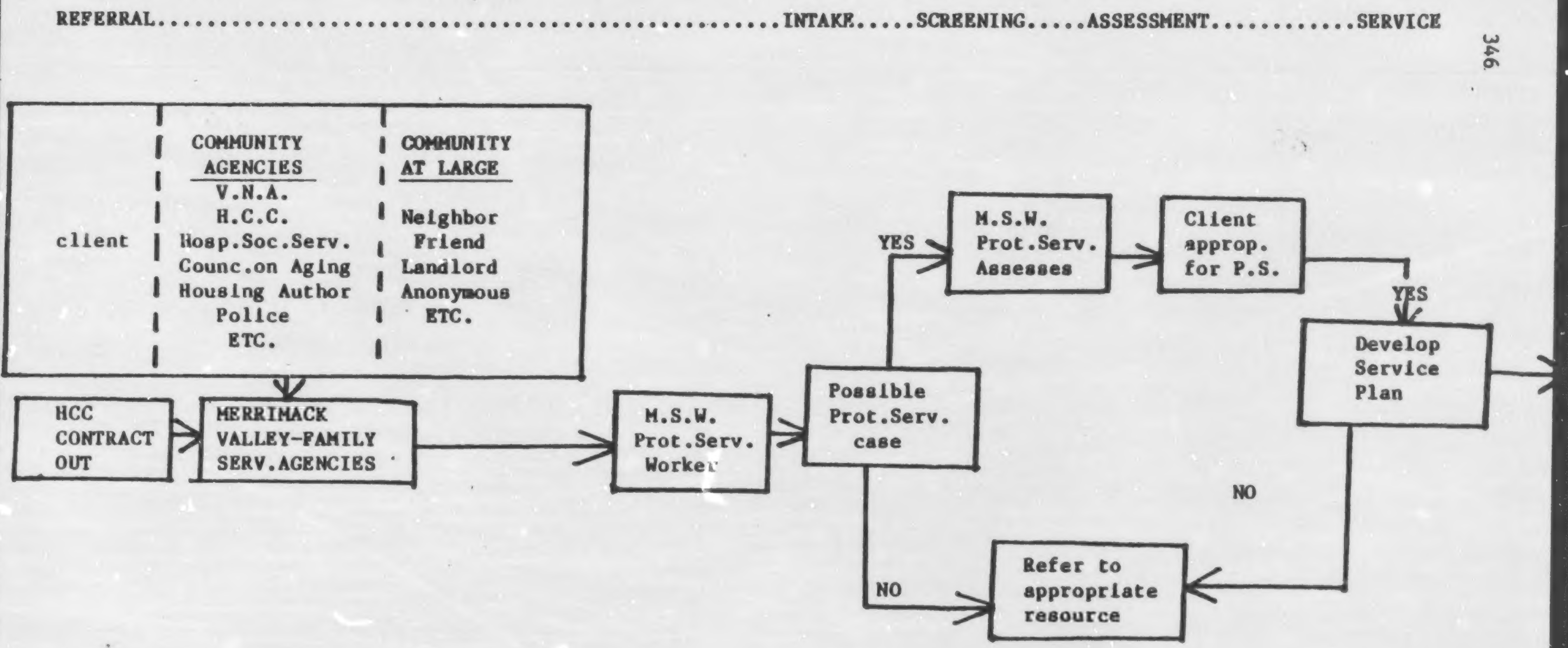
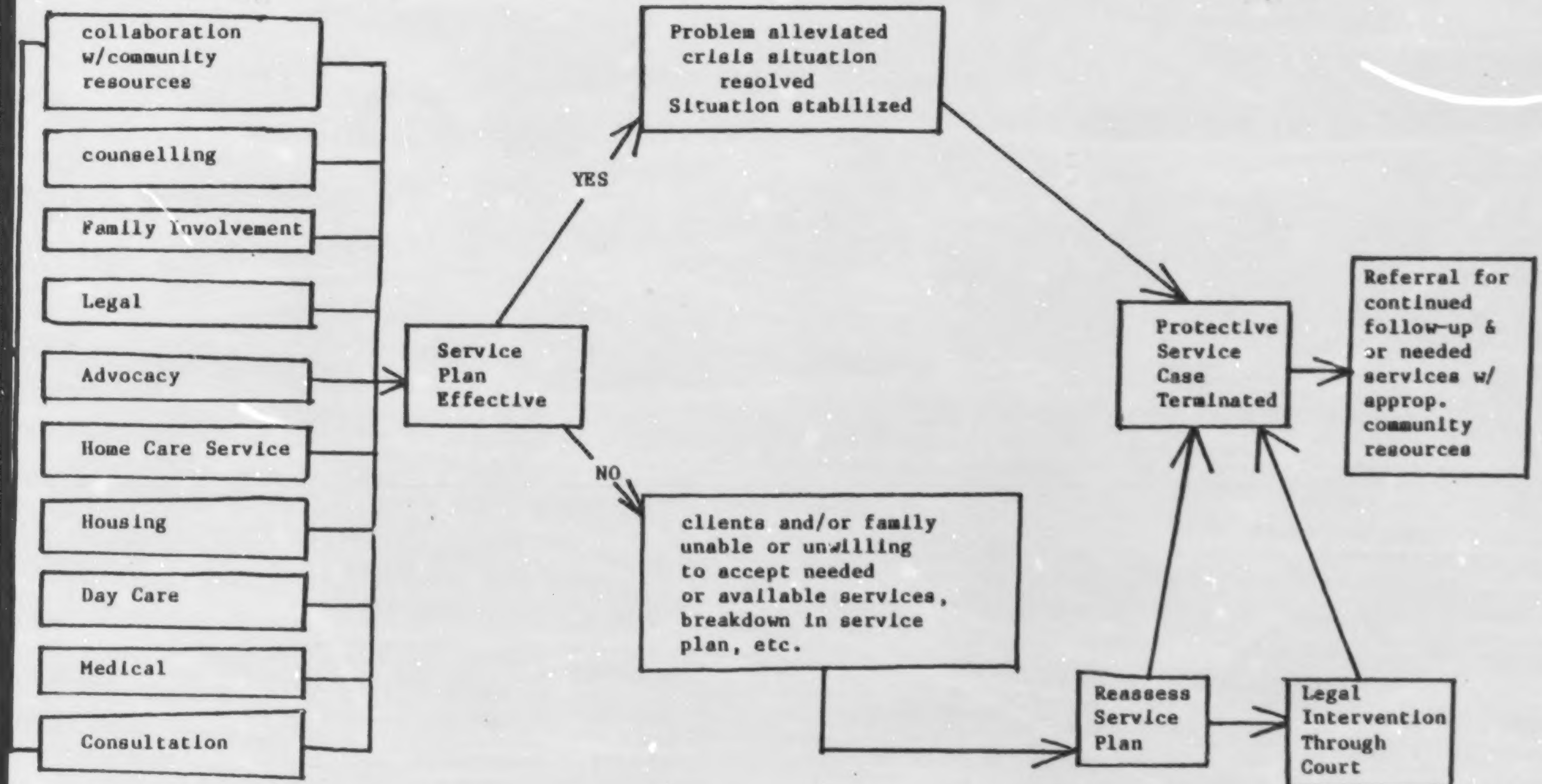

REFERRAL..INTAKE.....SCREENING.....ASSESSMENT............SERVICE
client
COMMUNITY AGENCIES
V.N.A.
H.C.C.
Hosp.Soc.Serv.
Counc.on Aging
Housing Author
Police
ETC.
COMMUNITY AT LARGE
Neighbor
Friend
Landlord
Anonymous
ETC.
HCC CONTRACT OUT
MERRIMACK VALLEY-FAMILY SERV.AGENCIES
M.S.W. Prot.Serv. Worker
Possible Prot.Serv. case
YES
M.S.W. Prot.Serv. Assesses
Client approp. for P.S.
YES
Develop Service Plan
NO
NO
Refer to appropriate resource

Figure 4

ESMV PROTECTIVE SERVICE

CLIENT FLOW CHART

PLANNING AND CO-ORDINATION..RE-EVALUATE AND TERMINATION.............


collaboration w/community resources
counselling
Family Involvement
Legal
Advocacy
Home Care Service
Housing
Day Care
Medical
Consultation
Service Plan Effective
YES
NO
Problem alleviated crisis situation resolved Situation stabilized
clients and/or family unable or unwilling to accept needed or available services, breakdown in service plan, etc.
Protective Service Case Terminated
Referral for continued follow-up & or needed services w/ approp. community resources
Reassess Service Plan
Legal Intervention Through Court

involvement is deemed appropriate, the worker will assist other community agencies in developing a service plan for the client.

The protective services worker may remain involved in a case until it is resolved. Resolution can take the form of the departure of the abuser, a reduction of hostility between abuser and abused, institutionalization or death of the client, among other possibilities. There is no clearly defined termination point for the protective services worker. This became clear in one interview:

Interviewer:	How much responsibility do you feel you have for a case over time?
Worker:	I will stay involved as long as I think I should be involved.
Interviewer:	When should you not be involved anymore?
Worker:	When the needs of the elder are being met adequately so that there is a feeling of safety. Once that is established, there is no reason for me to be involved, although there may be reasons for the homemaker or the VNA or day care to remain involved. There are some situations where it is unclear that abuse is going on. Then, I will stay involved but not active. I inform other agencies to let me know if they need help: the door is open.

The role of the protective services worker was frequently described in interviews as that of a consultant. The staff in community agencies tended to view the protective services worker as an outside party with specialized expertise in counseling, who could be brought in for advice when necessary. First, it will be helpful to present one protective service worker's formulation of the role:

> In [abuse/neglect] cases, a lot depends on the case itself. My role can simply be a consulting role...an outside, objective person looking at the case in a fresh way. Depending on what happens, I may have to get involved in the case in a nitty-gritty way, helping a person get a Medicaid application, etc. It varies depending on the landscape I see when I get involved in the situation.

He continued:

> Sometimes I am a gap-filler and sometimes I feel superfluous. Sometimes...nothing can be done. [Even then], in a way, I fill a purpose. Sometimes [agency staff] just want my impression. If my impression is the same as theirs, that nothing can be done, then that is helpful.

A similar viewpoint was expressed by a staff person at ESMV, in discussing the ESMV case manager's relationship to the protective services worker:

> Many times the case manager will call and say..."I'm not sure what to do," and the protective services worker will strictly consult. He may say: "Why don't you try this, have you tried that"—that kind of thing. He may never see the person, but give that kind of consultation because of the limitations of the hours he has to work.

There is thus a certain ambiguity regarding the protective service worker's role. Rather than having any specific legal powers, the protective services worker appears to be an "extra hand" called on when needed. Staff in some community agencies appreciated this lack of a clearly defined role, while others are more confused about what the protective services worker can do. One ESMV case manager stated: "To this day I am not clear on what protective services can do."

Similarly, the role of the protective services workers was perceived differently by various agency staff. One individual considered their major function to be trying to maintain elders in the community. Another person considered the protective services worker as strictly a counselor. He went on to say that "If I really suspected solid abuse, I would not contact protective services...If it's a realy heavy issue, it goes to my senior supervisor. I'd want the law involved as soon as possible."

Still other interviewees saw the protective services worker as the counselor and potential "ally" of the abuser. As a social worker in an adult day health center asserted:

> I function in so many different roles with the client that for me to go out and say [to the abuser] "Hey, you're abusing someone, so stop it!" - that's not my role, that is [the protective service workers] role...he can also befriend the person that's doing the abuse, whereas I can't. I'm taking care of the client, and he's taking care of the person that's doing the abuse. He is their counselor, and I am the abused person's counselor.

The somewhat undefined role of the protective services workers is not, however, necessarily a negative aspect of the program. The lack of formal responsibilities, such as those of a HCC case manager, allows the worker to perform a wide variety of tasks for a client. Thus, in addition to the role of "social work consultant," one could add "trouble-shooter." One protective services worker explained: "One day I am a counselor, some days an arbitrator or an investigator, and some days I provide direct services. It's so many things."

As a way of concluding and summarizing this description of the ESMV protective services program, two cases will be described. It is worthwhile to present these cases at length, for they demonstrate the complexity of elder abuse/neglect cases, and highlight the relationship of the protective services worker to other agencies. The first case presented by a protective services staff person was one of suspected psychological abuse.

> Protective Services Worker: May I give you an example. Recently, the [ESMV] case manager called us. There was concern about an elderly woman who was being browbeaten by her son with whom she lived. I would consider this emotional abuse. This is a family, son and mother, that have lived together for several years. They are the concern of the community, and other agencies are involved. Fortunately, I was able to visit with the people. One of the sources of fear on the part of the agencies was the background of the son. He has had a psychiatric problem, and I think that that is a kind of concern among some people. In any case, when he is under financial stress, which happens often—every so often with his credit cards, he uses them more than he should, and they are often after him—he gets angry, generally at the world, but takes it out on his mother. She complains to others at the day care center she attends. She will repeat what her son is doing. I went up there. Fortunately both were there. I was able to see it played out. The elderly

lady is fearful of staying alone and won't stay in the room herself, so she dogs his footsteps, follows, trotting after him. He is never by himself. During the period when he is under stress, he blows up at his mother, yells, gives her a terrible time. What I learned, and that is new for me, is that his mother is afraid of dying. She has a heart condition, and is afraid of dying by herself... This is what she says. I was hopeful of learning more about what is involved with her feelings, but could not. The kind of advice I gave was to keep her in day care as much as possible. During the period of financial stress, they are usually closer together and she will tend to cut down her day care attendance.

She said that she gets nervous and has diarrhea and doesn't want to go to day care. She uses that as an excuse.

Interviewer: I am curious. How did you gain entry?

Protective Services When the son is upset and angry, he will use the resources that are available. The son is known to [us]. He will call [us], as he has a good relationship with people in the agency. He understands that he has to vent his feelings.

Interviewer: This is one of the happier cases in a sense that there is a case where a person recognizes that he needs help. You recommended day care. There is counseling going on?

Protective Services Worker: No, but he may be involved with someone. In the past, we have supported him in continuing counseling. He is on medication and will discontinue it and that will contribute to his excitability and/or he will resume drinking. He is a bright man and will use the system. Our involvement is at a time of crisis.

Here, we see the temporary involvement of the protective services worker, and his or her role as an adjunct to persons who have on-going responsibility for the case (ESMV case manager and day care center staff). The emphasis on the family is evident, as is the recognition of a need to treat the abuser, as well as the abused. The protective services worker was primarily used to assess the severity of the situation and to suggest short-term remedies for it. At this point, the involvement of the worker terminated.

In the second case, the protective services worker's involvement was much more extensive, and took the form of actual on-going services to the client. This example of financial abuse was provided by an attorney at an elderly legal services project in the area, who works extensively with the protective services staff.

Attorney: Another case we are still working on is an elderly woman in her eighties. She has a home in the community. Some years ago she sold the home to somebody with a life estate provision. That means she can live in the house as long as she is alive, and when she dies, the house would go to the man. The purchaser paid her 35,000 dollars for the house. Some people in the neighborhood found out that she had this money, and managed to bilk her out of all of it, in dribs and drabs. This woman is ostensibly rational, she can talk to you, but she has really poor judgement, and is very lonely.

There was a young man who did most of its who is in his twenties. He said "I'm your friend, and I like you, and we will do all these things together." She was very happy to have him there, and would give him money. There was no way to persuade her that she shouldn't do this. She continued to do it. When the protective services worker got involved, she was being threatened with utility termination, and her real estate taxes had gone unpaid.

Interviewer: How did the protective services worker become involved?

Attorney: I believe that the purchaser of the property called. He called Elder Services, and it eventually got around to protective services. He called up because he saw this woman being taken advantage of, and he was furious because he had paid her all this money, and it was being whittled down. Plus it was the understanding of the purchase and sales agreement that she would keep up the property.

She is not willing to take any action to recover any of it. It's a real question as to whether she was competent or not. There is nobody to act as her guardian or conservator. The protective services worker has been acting as this, and she has been writing checks for this lady, and helping her do that, and keeping everything current. We've helped make payment plans on the utilities, and negotiated with the owner of the property, so he doesn't kick her out, which he has the right to do because she hasn't paid the taxes. At one point she was in the hospital, and the hospital had taken the extraordinary step of petitioning to be appointed this woman's guardian, so they could put her in a nursing home, because they did not want to send her home. She wanted to oppose it, and they decided to drop it. Now that was a difficult case for me, becuase I felt she belonged in a nursing home. But she is our client, she wants to stay home; its extremely difficult for me as a lawyer to deal with clients whose competence is questionable.

> The person who took all the money left after all the money was gone for several months, and he resurfaced a few months ago and is living with her. In the same house with her, with some other people: his girlfriend and an older woman. The protective services worker got a call from one of the neighbors who told her that these people had come back. We were very concerned that she would be subject to physical abuse, and that they would try to take her money. The protective services worker has control of her finances, she would know at this point if they took her money. She also notified the bank that this guy might be coming in to try to get some money. So they're on guard, and so far, nothing has happened.

This example, when compared to the previous one, shows the wide range of the protective service worker's activity. While in the first case the worker acted as a short-term consultant, in the second, she played a vital role over a considerable period of time, even taking over some of the management of the client's financial affairs. The two cases are similar in that the protective services workers were called in by other agencies. In the second example, however, the worker took a much more active role in managing the case.

In summary, in this model ESMV has contracted with three Family Service Associations to provide protective services to the elderly in the Merrimack Valley, including victims of elder abuse/neglect. The protective services workers can best be characterized as social work consultants who work with other agency staff on difficult cases. A certain degree of ambiguity was identified regarding the protective services worker's role and functions. This is probably due to the flexibility inherent in the position.

Conclusion

Since a substantial portion of the remainder of this paper is devoted to a comparison of the two models, only the most obvious difference between the two programs will be noted here:

CES assigns abused/neglected clients randomly to case managers, while ESMV uses specialized protective services workers. While the value of expertise in dealing with problem clients has not been concretely demonstrated, a strength of the ESMV program is clearly the presumed competence of these workers. On the other hand, the power of the case manager is greater, in that he or she can directly authorize services for the client. This internal vs. external dimension is a key variable in comparing the two models.

V. IMPLEMENTATION

A major concern of this organizational analysis is the replicability of the two models. In particular, it is important to ascertain whether each program is purely the product of a specific local service environment and distinct historical factors. If that is the case, then it may be difficult to replicate the model elsewhere. Beyond this, a description of problems in the implementation of these two programs can assist others interested in developing projects to aid abused/neglected elders.

Coastline Elderly Services

As noted above, CES does not have a separate protective services program. Since it assigns abused/neglected clients to generic case managers, no implementation problems existed. There is one historical factor, however, which has been of some importance in CES's approach to elder abuse/neglect: its participation in an area-wide, interagency task force convened by the local district attorney's office. While this task force no longer meets, it was instrumental in calling attention to abuse/neglect in the area. As will be discussed below, however, it is questionable whether this task force had any enduring effect.

In early 1980, the director of the New Bedford Council on Aging approached the district attorney of Bristol County. In a letter, he reported that a number of elder abuse/neglect cases had come to his attention, and proposed a meeting with the DA and his staff to discuss the problem. At the meeting, the Council on Aging director reported his frustration, and that of other agencies, regarding abuse cases. In particular, he stressed the difficulty of gaining entry into the abuse situation. He felt that the power of the DA's office could be brought to bear on the problem. The DA was very responsive to this request, and assigned a staff person to plan a large meeting of all agencies concerned with the problem.

Thus, the DA's office assumed the lead role in convening an interagency task force on elder abuse. A letter was sent out from the DA's office announcing a meeting, and about 25 agency representatives attended. The agencies involved included CES, the health department, St. Luke's Hospital in New Bedford, VNAs, Southeastern Massachusetts University, Mental Health, police departments, and local social service agencies.

The task force was not conceived of as an on-going group. Its task was to set up a standard procedure for the handling of abuse/neglect cases. After three or four meetings, it was decided that CES should be the central agency to which these cases should be initially referred. Task force members concurred that CES was the only agency with appropriate resources to investigate suspected abuse/neglect. CES did not add or reassign any staff to carry out this function; it was assumed that generic case managers would fill this role. After CES was identified as the primary referral agency, the task force ceased to exist. As the staff person at the DA's office noted: "I think once we decided what the procedure should be, we didn't really need to meet."

From our interviews, it appears that the impact of the Task Force was very small. As one interviewee stated: "That wasn't really a task force, but more like public relations." Along the same lines, when a CES employee was asked "How much is what you're doing since the task force different from what you did previously?" she responded:

> Nothing. We had been [dealing with abuse cases] prior to the task force. That was something we just put together ourselves. We decided right from the start that two people should always go out on a case. Eventually, we had gotten enough calls that we started establishing certain contacts, people we kept talking to and meeting

> with. Through them we established contacts, so that we had a person to call in each agency and get immediate action if we needed it. We went blind in the beginning, and because we had been doing it, I guess word had gotten out in the community. It became a known thing to call Coastline when there was an abuse case. It became automatic.

It seems likely, then, that the task force had only a superficial impact on elder abuse in the area, although it did confer legitimacy on CES's approach to abuse/neglect. A second factor, however, was also considered important by some individuals we spoke to: the somewhat unusual willingness of the DA's office to involve itself in cases of elder abuse. The supposed relationship of the DA's office to CES was in fact one of the major reasons why CES was selected for the present study.

From the interviews, it appears as if the tie to the DA's office is largely ephemeral. Interviewees were only able to report one or two cases in which the DA's office was involved. One case manager who had been at CES for over two years was unaware of the involvement of the DA's office. While the concept of working with a law enforcement agency may make sense in the abstract, it has not turned into a close collaborative relationship in this area.

It is worth noting that CES is currently considering reconvening the task force in modified form. The point of this reconstituted task force would be to make interagency case coordination a reality. A CES staff person described her plan for this:

> I hope that we can meet quarterly, with a number of disciplines, not what was started before [with the previous task force]...Where I see the task force heading is getting disciplines like mental health, nursing, medical, home care, police, the DA, and legal services together—no more than a dozen people...That's where it belongs, to discuss hypothetical cases, techniques, and cases you are presently working with, to get other ideas. That's where I hope it heads.

She went on to note that even this modified task force may prove unnecessary, as "we have always been doing this informally...Most likely you would call in the majority of those disciplines on a case anyway."

In summary, two historical factors were identified to the evaluation team at the outset of this study: the presence of an interagency task force, and close ties between CES and the District Attorney's office. At the time of our evaluation, neither of these elements appeared to strongly influence CES's activities in the area of abuse/neglect. Case managers and supervisors did not report extensive contact with the DA's office, and the community agency staff we interviewed seemed largely unaware of the DA's willingness to assist in cases of abuse/neglect. Similarly, the task force had not met for a number of years, although it did convene once in June, 1982 for the benefit of the evaluation team.

For these reasons, it is possible to consider the CES protective services model as that of a standard HCC. The question arises as to whether the task force could have had a more enduring impact, and why it ceased to function. Warren, et al. report the finding that such high-level interagency groups are in general ineffective in developing an integrated organizational network.[6] As staff at CES acknowledge, of much greater importance is informal day-to-day interaction with related agencies. While it is certain that the task force did no harm, it is extremely unlikely that it produced any changes in the way local agencies handle cases of abuse/neglect.

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[6] Warren, R., S.M. Rose, and A.F. Bergunder. The Structure of Urban Reform. Lexington, MA.: D.C. Heath, 1974.

Elder Services of the Merrimack Valley

Since CES's model is the standard HCC procedure, implementation poses no problems whatsoever. Other HCCs by definition have the ability to employ this model. While implementation problems could arise for the ESMV model, they are unlikely to occur, due to its external nature: contracting-out is the least disruptive to the sponsoring agency of the remaining three models. This becomes clear in the following brief review of the ESMV project.

The Family Service Associations of Lowell, Lawrence, and Haverhill are old, well-established agencies with substantial credibility in their communities. The agencies were founded in 1912, 1854, and 1866 respectively, and have historically provided services to younger families with children. In recent years, the focus has expanded to include the elderly. There has also been a history of cooperation between the three agencies. They had worked together on staff training, on a legislator's breakfast to discuss problems with Title XX funding, and other issues. According to one source, the presidents and executive directors of the three agencies had been meeting regularly for some time prior to the joint project.

In 1977, staff persons at ESMV contacted the director of the Lowell Family Service Association to see if there was interest in providing protective services. The invitation was extended to the other two agencies as well, and all three began to do protective services work for ESMV on a fee-for-service basis. In 1978, ESMV formally contracted with the Family Service Associations. The funds are channeled through the Lawrence agency, which administers the contract. Funds are divided based on the percentage of the area population each agency covers. Lowell receives the largest portion of the funding, Haverhill the smallest, and Lawrence falls between these two.

As none of the current protective services workers were those originally employed by the program, it was impossible to determine in detail the implementation problems that existed. However, one administrator who had been involved with the program since its inception noted that no real problems were experienced. The relationship with ESMV had developed gradually, so conflict was avoided there. Other community agencies were only too willing to call on the protective services worker.

In summary, there appears to be nothing in the historical development of this program that would inhibit its development elsewhere. Implementation occurred smoothly, and acceptance by other agencies was speedily forthcoming. Since the model involves contracting-out, ESMV avoided time-consuming activities related to program design, staff selection, and in-service training. By selecting well-established community agencies, ESMV avoided problems with local acceptance of the program.

Conclusion

It is difficult to contrast these two programs in terms of implementation, for at CES, no new program was implemented. Attempts were made to strengthen CES's on-going activities with abused/neglected elders through an interagency task force and ties to the DA's office. These attempts appear to have had little, if any, effect on the program.

By contracting out for protective services, ESMV insured that it would have a minimum of implementation problems. By selecting well-established community agencies as providers of protective services, it avoided difficulties in initiating and gaining legitimacy for a new program. As such, no unique historical factors make the ESMV model inappropriate for other areas, with one obvious exception. If no local agencies have the same level of expertise and community acceptance as the Family Service Associations in the Merrimack Valley, problems in implementation could in fact occur. The replicability of both models will be taken up further in Section VII.

VI. INTERAGENCY COORDINATION

In recent years, an intense interest has developed in interagency coordination. Case management programs are springing up in many human services fields. In long-term care, the Channeling Demonstration Project is devoted to fostering coordination of health and social services. Van de Ven and Ferry suggest one major reason for this interest:

> Many complex social and economic problems require joint interorganizational planning and programming because the requisite resources, expertise, and motivation are contained within autonomous organizations and vested interest groups. Thus, organizations must increasingly establish coordinated relationships with other agencies, creating, in effect, organizations of organizations.[7]

Such interagency coordination is especially important in cases of elder abuse/neglect. While the precise extent of abuse and neglect of the elderly is not known, it is clear that such cases are often extremely complex and difficult. They generally require the involvement of a number of social service, health, and/or legal agencies before they are resolved. A critical question for our organizational analysis is therefore: How does interagency coordination take place in these two models? We begin this section by discussing patterns of referral. Following this, coordination of specific cases is treated.

Referral Patterns. Coastline Elderly Services

It was not possible to quantify the number of abuse/neglect referrals CES receives from various sources. Based on the impressions of agency staff, however, it is possible to give a general picture of referral patterns. A sizeable majority of abuse/neglect cases are generated from the agency's client population, as would be expected. The most frequent external referral sources are Visting Nurse Associations. Occasional referrals come from local mental health agencies, friends and neighbors, Councils on Aging, staff in housing projects, and clergy, roughly in declining order. While CES staff identified St. Luke's Hospital as a referral source, persons there only reported a few cases of collaboration on neglect cases, and none on abuse.

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[7] Van de Ven, A.H. and D.L. Ferry. Measuring and Assessing Organizations. New York: Wiley, 1980.

CES staff tends to make referrals to the same set of agencies. VNAs were most frequently cited as agencies to which clients were referred, followed closely by mental health agencies and legal services. Interviews with CES personnel showed a very good awareness both of the importance of working with other agencies, and of the specific resources available for referral. As one supervisor noted:

> Through different types of abuse cases, I've learned about other agencies and what's available. So now I know where I can go for what I need...You develop a resource network [and beyond that] established contacts. You get to know who the person is that can be the most help to you, and you start to utilize them.

Considering the time limitations of CES case managers, utilization of the referral network appears quite extensive.

Referral Patterns: Elder Services of the Merrimack Valley

The referral pattern for the protective services program is somewhat more complex, because each worker has developed a particular set of relationships in his or her area. Their location outside of the HCC has fostered a wider involvement with other agencies on elder abuse/neglect cases than was observed at CES.

The major source of referrals for all three workers was ESMV. However, ESMV referrals form only a plurality of protective services clients. One worker identified the VNA and legal services as the next most frequent referral sources; another cited mental health agencies and the VNA as relatively equal sources after ESMV; the third cited a day care center, neighbors, and friends. The housing authority was an additional occasional source of referrals. Hospitals were considered to be unimportant sources of referral.

Protective service workers are likely to refer their clients to ESMV for home care services, to legal services, to VNAs, and to Mental Health Centers. The workers were extremely knowledgable about resources in their areas. Since they are not a part of an elderly service agency with its own caseload, external referrals naturally form their clientele. For this reason, their contact and communication with other agencies appeares to be greater than the CES case managers. One protective services staff person noted that it is different "from when the resources are all in one agency. Here, we use the resources in the community, which requires cooperation and a little more tact."

Such increased contact with other agencies may in part be due to the unique service environment in the Merrimack Valley. It was frequently reported that elderly service agencies in the area have formed a strong network, with ESMV acting as a catalyst for this. The protective service workers have thus benefitted from a strong and supportive service environment. The protective services program is a part of what one community agency staff person described as "an excellent system of integration (of) agencies." The extensive referral system is one aspect of this high degree of integration.

The second aspect of interagency coordination is that of cooperation on the management of specific cases. Here, we ask: What is the role of the CES case manager and the ESMV protective service worker vis-a-vis staff in other agencies? This question is answered in the following two sub-sections.

Case Coordination: Coastline Elderly Services

At present, there is no formal mechanism for case coordination at CES. No regular meetings of area service providers take place in which cases of elder abuse/neglect can routinely be discussed. Although the establishment of an interagency group is under consideration, it has not been called together. On an informal level, however, CES is firmly imbedded in the elder services network in its area. Its workers report day-to-day collaboration with other providers on protective services cases. This was supported by interviews with community agency staff.

It is important to note that the role of the CES case manager is substantially different from that of the ESMV protective services worker. The former has the ability to directly authorize social services; for this reason, other agencies approach the case manager to coordinate service delivery. The VNA will thus almost invariably consult with a case manager when both serve the same client. This is done in order to develop a complete service package for a client, and to avoid duplication of services (for example, both attempting to manage the case). Coordination around abuse/neglect cases can be seen as an extension of this on-going collaboration.

The most common contact with VNAs and other agencies is by telephone. Any one of the agencies in the service network feels free to call to consult on a case. This informal coordination process was described to us by a CES supervisor.

Interviewer: What happens when you get calls from other agencies?

Supervisor: First you try to get as much information about what's going on as possible. We need to see if it's appropriate for us to even handle it, rather than, say, mental health, or another agency. Sometimes we find that some people are under the guideline age of 60, and we have to refer it back to the welfare department or the Department of Social Services. Sometimes grandparents might be being abused by a minor ward; then we have to refer to welfare or whatever. If there is an elder involved, we will usually assist them, and go out on a visit together. Or if its financial abuse, therefore it might be something that we can turn over to legal, and they'll handle it for us.

Interviewer: But who in that case runs the case, establishes the contact with the abused?

Supervisor: If it's financial, legal services. They would make an initial contact over the phone. We will often have a case conference. They will make their decision on what we give them.

With VNA, if we are working on case together that may be dangerous, we go out together. On occasion, we have gone out together. When it's clearly a medical problem, it's a job for the VNA.

Then, if they go into the hospital, VNA will call us, because the situation isn't resolved, he will have to go home, and what we do is work with the case. At that point, we will take over the case. If they are still involved in the case, we would stay in contact with each other.

In the absence of formal procedures for case coordination, interagency relationships are worked out on a case-by-case basis. If the case manager encounters a case in which counseling is the only service need, he or she will stay involved only until the local Mental Health Center takes over. Similarly, if no HCC services are needed in a case of material abuse, a referral will be made to legal services, and the case manager's involvement will end. The case manager's role in the case is so strongly tied to the provision of services that often little justification can be found for continuing involvement if these services are unnecessary. This stands in obvious contrast to the ESMV protective service worker's role, who does not offer supportive services, but specialized expertise in abuse/neglect.

Interagency coordination in the CES model is thus highly fluid, and the amount of interaction that takes place in any individual case depends on a wide variety of variables. These include: 1) the eligibility of the abused/neglected individual for HCC services; 2) the major problem of the client (legal, financial, social, health, etc.); and 3) the personal contacts of each case manager in other agencies. These variables make for considerable differences in approach between cases.

Staff at CES and community agencies universally expressed satisfaction with their relationship. CES case managers and supervisors singled out at different points the VNAs, mental health, and legal services as being especially responsive to attempts at case coordination. The police and members of the clergy were also noted as participants on cases. In summary, although formal mechanisms for interagency case coordination do not exist, CES staff do have reliable informal methods to accomplish this.

Case Coordination: Elder Services of the Merrimack Valley

A clear understanding of case coordination in this program is considerably more difficult to obtain that for CES. In the ESMV project, each of the three workers has somewhat different resources to call upon in their areas, and different types of relationships with local agencies. This became obvious in the discussion of referral sources, above: different agencies refer to different workers. In spite of this, based on the interviews, it is possible to generalize to a degree about the role of the protective services worker in case coordination. Where appropriate, variations between individual workers will be noted.

It should be stated at the outset that the Merrimack Valley appears to have an unusual amount of interaction and coordination among agencies that serve the elderly. Every interviewee referred to the exceptional integration of different efforts in the area. In order to demonstrate this, interviewees referred to both formal and informal mechanisms. These will be taken in turn.

A significant amount of the formal coordination is the result of efforts by ESMV. As one respondent stated: "Elder Services has a hold on us. It was Elder Services that was instrumental in bringing us together...It took Elder Services to get us together in one room." Said another: "Elder Services has done a good job of trying to establish an elder network." This sentiment was echoed by many others.

The primary formal mechanism established by ESMV is the "Aging Network" meeting, which takes place once a month. The function of these meetings was described by a protective services worker:

> Elder Services takes the initiative on these meetings. They involve senior aides, various agencies in the network, others. It is an opportunity for new programs to be mentioned or to address problems. There was a health task force to identify needs, [issues in] mental health services that the network wanted to address as a group. There is also a hidden agenda. The meetings are a way of becoming acquainted with the network where one could meet people. It is also a source of information.

These meetings are not devoted to clinical discussion of specific home care cases. Instead, they are devoted to more general issues affecting the area's elderly. Another protective services worker further elaborated on the role of the Network meetings: "Those meetings give the elder network in the area an identity so that when it comes time to make a call, there is a feeling of working together which facilitates the work of everybody."

Clearly, these meetings are not organized to deal with problems of abuse/neglect; the official topic of the meeting is only occasionally related to this theme. However, the meetings are extremely important for the protective services workers, in that they provide a much-needed opportunity to establish contacts with area providers. This leads to referrals for their services, as well as persons to contact for help with crisis situations.

Another type of formal coordination exists, but in this case it is between the three Family Service Associations themselves. ESMV requires that two meetings take place each month. One of these is primarily administrative; protective services workers, Family Service Association administrators, and ESMV program staff attend. The other meeting is clinically oriented, and is attended primarily by the three workers, although administrators sometimes attend. This clinical conference was described by all participants as highly useful. They noted that these meetings were important ways of gaining support for their work.

A third formal method of case coordination takes place in one sub-area of the grant: Haverhill. There, ESMV has given small grants to three agencies: one that offers counseling, another than provides mental health homemakers, and the protective services project. As one participant described the process:

> These three agencies were functioning independently [at the time of the grant] and in an effort to...avoid duplication of services and to coordinate and strengthen service, ESMV asked us to meet every three weeks, and to quarterly have the administrators of the program to meet in administrative session, to discuss the coordination of the programs.
>
> The other meetings [every three weeks] are clinical meetings. They are splendid; they increase the effectiveness of all the programs.

Three strong formal mechanisms for case coordination thus exist in the Merrimack Valley. By all accounts, these strengthen the ability of the protective services program to deal with cases of abuse/neglect. The opportunities for regular interaction with other service providers is crucial in this case, for the location of the workers in Family Service Associations could isolate them from the network of agencies that specifically serve the elderly. By participating in at least the Aging Network meetings, the protective service workers demonstrate their willingness to work with other providers.

It is an interesting question as to why the interagency Aging Network group proved to be a successful mechanism for on-going interagency contact, while the New Bedford task force did not. The most likely reason for this is probably the broader scope of the Merrimack Valley group. While agencies may not have felt a need to meet regularly on abuse/neglect issues,* they do see a group with a more general focus on elderly issues as important to attend. If attempts are made by CES to re-establish the task force, broadening its concern beyond abuse/neglect appears advisable.

ESMV is also able to exert a considerable amount of control because it is the source of funds for a number of agencies in the area. Due to financial ties, these agencies are more likely to attend the meetings. Further, the ESMV protective services workers generate few, if any, cases from their own agencies. In a sense, formal interagency meetings provide an important opportunity to market their services. It is likely that the success of this model depends to some degree on establishing appropriate formal mechanisms for coordination between protective service staff and other agencies.

While formal mechanisms play an important role in coordination of services to abused/neglected clients, the most important relationships are worked out informally, in the context of day-to-day interaction. The protective services workers paint a picture of an on-going process of negotiation, which requires considerable tact and flexibility on their part. They emphasize the difficulty of precisely stating how case coordination takes place, and stressed variations from case to case.

One protective services worker described the process at length:

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*One LES interviewee noted: "There aren't enough cases to meet regularly."

> In most instances, Elder Services, the VNA, the Council on Aging, and/or Public Health will remain involved [on a case]. The way we work it out depends on who has had the relationship with the client...It is important to determine who is the key person. Usually each person has a specific role. We try to decide who is the key person for the client--they are the ones with the client's basic trust--and then have that person stay in the key role. We try to divide and clarify who is going to do what.
>
> I will always contact the other agencies on a case, to talk about what other options, what else we can try. We can sometimes work things out on the telephone. If another agency is involved on a regular basis, I will call them. If there are instances where there are a lot of problems going on, depending on the situation, we will have a conference and try to clarify it...
>
> If the VNA is involved, they have the medical-health responsibility. I may get a call from them, and they are overwhelmed with the social, case management functions...

The process is thus a highly fluid one, about which it is difficult to make abstract generalizations. However, two major themes emerged from the interviews: the protective service worker's relationship with ESMV on one hand, and with other agencies on the other.

Where there is collaboration on a case, it is important for the ESMV case manager and protective services worker to decide who will be primarily responsible. As an ESMV program staff person noted: "It is strictly a case-by-case situation. If the case manager has a very good relationship with the individual and feels that it wouldn't serve the client as well to turn that case over to have it work as a team then they will do it. If it makes more sense, then it goes to [the case manager] and that person handles it."

This decision-making process is quite ambiguous, as our interviews showed. One community agency staff person asserted that the ESMV case manager should have ultimate responsibility for the case, because "the case manager at Elder Services is the clearing house for all services." A case manager, however, said that this varies: "if the real need is for services, the case manager takes the lead; if counseling is the primary requirement, the protective services worker does." Still another interviewee stated that if a case manager brings in protective services, "once the protective services worker gets in, that person should be in charge of the case."

The interviews reveal, however, that the role of the protective services worker is not in general to "be in charge of the case." The most pressing needs of many of the clients are for concrete social and health services that the protective services worker does not provide. It appears that the ESMV case manager, who does have direct responsibility for services, is considerably more likely to maintain ultimate responsibility for the case than is the protective services worker. As noted earlier, the protective services worker's role is that of counselor, trouble shooter, and social work consultant. As such, it is less conducive to taking charge of a case than is the ongoing, monitoring role of the ESMV case manager.

Relationships with other agencies must also be worked out in day-to-day interaction around cases. Interviews with community agencies revealed three general conceptions of the role of the protective services worker. First, the protective services worker was seen as simply "extra help" on a case. Without reference to expertise, agency staff reported that it "felt good" to have an impartial third party to call in on a case.

The second conception of the protective services worker was related to special expertise. The workers were frequently seen as the person who does the "social work;" that is, who assesses and counsels an abused/neglected person. as a legal services attorney stated:

> We of necessity do an awful lot of counseling, social-type work, in our legal practice, but my feeling is that we're not trained social workers or psychologists and its really better where possible to get someone who is.

Finally, the protective services worker can occasionally be used as an authority figure in a case. To give another example from our interviews, a social worker in a day care center reported:

> [The protective services worker] has more power behind him. He is the protective services worker, while I am the social worker from the day care center. So if I know you are beating up your wife, big deal. They don't necessarily known that [the protective services worker] has nothing legally backing him up.

The last statement--lack of legal back-up--puts serious limitations on this role, which will be discussed in the following section.

Regardless of their conception of their role, community agency staff (as distinguished from ESMV) reported satisfaction with the protective service workers. The workers were described with considerable admiration and respect. For example:

> "...a wonderful, sensitive, gifted social worker. I'm just extremely impressed with her ability to work with some of the most frustrating cases we get."
>
> "He is always there..."
>
> "She's excellent!"
>
> "...they are doing a good job. They have an expertise that they contribute to the program here."

This high level of support for the workers as individuals certainly increases their effectiveness in dealing with other local agencies.

Comparison

Before concluding, it will be useful to compare the CES and ESMV approaches to interagency coordination in four areas:

1) Who controls decision making on a case?

The CES case manager is much more likely to have ultimate responsibility for a case than the ESMV protective service worker. The case manager authorizes services and has a mandated responsibility to monitor a case. The protective services worker occupies a consulting role to a greater degree. Although he or she may have primary responsibility for managing and monitoring a few cases, this is not the norm. Case managers have considerably more authority, as conceptualized by Beatrice.[8]

2) What formal case coordination mechanisms exist?

No formal mechanisms for case coordination were identified in CES's program. ESMV protective services workers participate in a monthly Aging Network meeting, and meet with one another twice each month. The protective service worker in Haverhill meets every three weeks with two other agencies. Formal attempts at case coordination are thus considerably stronger in the ESMV program.

3) Who is responsible for monitoring and following-up cases?

The CES case manager routinely stays involved in an abuse/neglect case until it is resolved. This is especially true if the abused/neglected client is eligible and willing to receive services from CES. The ESMV protective services worker does not have the official responsibility to monitor a case, and does this less frequently.

4) To what degree does informal case coordination take place?

While this is impossible to quantify, the interviews indicate that ESMV protective service workers interact more frequently with a wider variety of other agencies than do case managers at CES. This higher level of interaction is due to fundamental differences between the two models. The ESMV worker has no caseload developed within his or her agency. By definition, he or she must work with other agencies to be involved with abuse/neglect cases at all. The case manager, on the other hand, has a large caseload and an array of services to offer on his or her own. While case coordination is important here as well it is less immediately necessary than for the protective services worker. Finally, the time of the case manager is more constrained, making him or her less able to engage in interagency collaboration.

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[8] Beatrice, D. "Case Management: A Policy Option for Long-Term Care." In J.J. Callahan and S.S. Wallach, eds., Reforming the Long-Term Care System, Lexington, MA.: Lexington Books, 1981, pp. 121-161.

VII. EVALUATION OF MODELS

It was stated at the outset of this report that a definitive evaluation of the two models was beyond the scope of this effort. We have therefore concentrated on describing the models in detail, and have identified strengths and weaknesses of each in the process. In this section, we will attempt to go beyond simple description, and point out positive and negative aspects of both programs more systematically. First, we report the criticisms and suggestions for model improvement of interviewees. Second, using a framework developed by Butler-West, et al., we will discuss the relative advantages and disadvantages of each program.

Respondents' Views of the Models: Coastline Elderly Services

The case managers we interviewed reported feeling competent to handle cases of abuse/neglect. The opinion of community agency staff was similar: they felt that the best alternative in such a case was a referral to CES. Three gaps in the program were identified, however.

The first is the lack of time on the part of the case manager to effectively deal with complicated abuse/neglect cases. Most case managers' caseloads are quite high, and much of their time is taken up by routine duties. They are therefore sometimes unable to devote sufficient attention to an abuse/neglect case, or to collaborate with other service providers.

Second, a need for specialized training was expressed. The most training in abuse/neglect cases that any case manager had received was one workshop on the issue. Some interviewees felt that additional in-service training in identifying and intervening in cases of abuse/neglect would be helpful.

Third, almost all respondents cited a need for more legal authority to intervene in cases of verified or suspected abuse/neglect. When asked about her experience working with other agencies, one case manager replied:

> It works all right to a certain point, but I think everybody gets a little fed up when they find they are banging their heads against a wall, when a case is getting nowhere. The need is for legislation, I guess, and protective services, with a mandatory reporting law. Nobody seems to know what to do when they get an abuse case.

We asked the respondents whether they favored the current CES approach, or felt one of two others would help the agency: a contracted-out model, or a specialist or special team in the agency. The response was strongly in favor of some kind of protective services specialist (individual or team) within the agency. The most favorable response came from CES staff themselves: all felt that an in-house protective services worker would assist them in dealing with abused/neglected clients.

Respondents' Views of the Models: Elder Services of the Merrimack Valley

Interestingly, impressions of the ESMV program are somewhat mixed. While interviewees were satisfied with the model in general, they were quite candid in pointing out its weaknesses. Two of the three areas for improvement cited in CES (time and legal authority) were also noted for ESMV. These will be described first, and then other suggestions for model improvement specific to ESMV will be presented.

Problems related to access to the protective services worker were frequently noted. As one ESMV case manager noted:

> If you have a crisis on your hands and your half-time protective service worker is only available Thursday afternoon, you have to look elsewhere. With the Mental Health Center, if those people are in the field you can call them at clients' houses and you can even reach them by beeper for emergency situations. They are available as frequently as we are: 37 1/2 hours a week.

Similarly, a community agency social worker, when asked how to improve the protective services program, replied: "Make [the worker] full-time!"

Although this sentiment was almost universally expressed, it was understood that limitations in funding will not allow this to change substantially. A legal services attorney stated: "I think [protective services] needs more workers and more money, like everybody else in the human services these days. she [the protective services worker] is terribly over-worked."

The need for greater legal authority was repeated by every interviewee. For example, one person asserted: "It would be nice if they had more muscle. They can go in as a social worker and say I want you to leave this person alone, but they can't follow through on it. It would be better to have more back-up on it, perhaps police back-up." Others cited a need for more power: "They are so limited in what they can do." Some respondents suggested that mandatory reporting would help increase the protective services worker's effectiveness.

Beyond these two areas which are largely beyond the control of ESMV, criticisms were levelled at the model itself. The severest of these came from the three ESMV case managers we interviewed. Two of these described cases in which they requested help from the protective services worker and were disappointed. One case manager reported that the protective services worker was contacted, but "I couldn't see anything happening. All the protective services worker was doing was discussing it with the client and not getting anyplace. So I got [the client's] signature on a piece of paper, which gave me the right to contact legal services."*

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*It should be noted that it is unclear whether this experience took place with the current or previous protective services worker.

In the other instance, the protective services worker declined involvement in a case, saying that the case manager appeared to have it under control; the case manager did not agree. Based on this and other experiences, she stated:

> Case managers often do not call in the protective services worker because the protective services worker doesn't have anything to offer, except as a consultant. They have no legal power to deal with abuse, no practical, hands on service they can offer. They are a glorified social worker or case manager. They are not really used that frequently. Legal services and Mental Health have something more concrete to offer.

The third case manager was more positive. She reported being in contact with the protective services worker as often as daily when working on an abuse/neglect case. She also expressed considerable admiration for the worker. In spite of this, however, she suggested a major change in the model. Her good relationship notwithstanding, she expressed a preference for having an in-house protective services worker at ESMV. She observed: "If they were here, you would feel freer to call the worker. You could discuss things with them more easily. This would be ideal."

It must be stressed that these sentiments are not necessarily representative of all ESMV case managers. Further, these opinions do not in themselves indicate that the protective services workers are not functioning effectively. These responses as likely reflect a lack of understanding of the purposes of the program, and its necessarily limited scope, due to lack of funds. However, it is advisable that the relationship between case managers and protective service workers be further explored, to determine ways in which cooperation can be increased.

As noted in the previous section, staff in other community agencies report a high degree of satisfaction with the program. All respondents felt that the contracting model was a good one. One respondent felt that "it is advantageous to have two agencies involved, so if one isn't hitting it off so well with a client, then they can turn to the other one." Others worried about their access to the worker if he or she were located in ESMV.

The protective services workers themselves were surprisingly candid about their evaluation of the model. On the whole, they preferred their location in the Family Service Associations. They felt that their role gives them what one described as "a fresh, outside view of the client." One worker noted the in-depth knowledge of community resources locally-based workers can obtain. However, all three workers identified coordination as one problem inherent in the model. One worker stated the opinion:

> There has been friction between this agency and Elder Services. When you get different agencies involved, you have layers of relationships that have to be developed...A big disadvantage is the problem of coordinating services. If, for instance, protective services were being provided out of Elder Services, then there wouldn't be a problem of coordination.

It is clear from the interviews that there is strong support from community agencies to continue a protective services program, and a willingness on the part of ESMV to do so. The question of the optimal form such a program should take is, however, not entirely resolved. In the following section, the positive and negative aspects of both models will be further reviewed.

Advantages and Disadvantages of the Two Models

The sheer quantity of descriptive data amassed for this organizational analysis makes systematic comparison difficult. As a way of summarizing the material in this report, we have chosen to employ the framework developed by Butler-West, et al.[9] Those authors prepared a set of "pros" and "cons" for each of the four models they describe. On the following pages, the advantages and disadvantages proposed by Butler-West, et. al. of the two models studied here are presented, with comments from our research on CES and ESMV. In some cases, our findings match those of Butler-West, et. al.; in other cases, there are discrepancies. This presentation will highlight differences between the two models.

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[9] Op. Cit., pp. 58-9.

A SUMMARY OF THE ADVANTAGES AND DISADVANTAGES ASSOCIATED WITH THE TWO ADMINISTRATIVE MODELS

INTERNAL, GENERIC CASE MANAGER MODEL: Coastline Elderly Services

PRO

1. Involves no start up costs and permits the level of resources committed to vary with the level of demand.

COMMENT: This was found to be true for CES.

2. Utilizes existing service structures and interagency linkages, thereby not affecting managerial complexity.

COMMENT: This was found to be true for CES.

3. Can prevent burnout which is frequently associated with protective service workers.

COMMENT: This does not appear to be true for CES. Case managers can "burn-out" on a severe case of abuse/neglect, which affects their performance in the remainder of their duties. Unlike a protective services worker, they are not trained to deal with "burn-out."

4. Equal distribution of protective services cases:

    - allows for efficient use of staff time preventing potential under-utilization
    - allows all case managers to develop some degree of expertise in protective services

CON

1. The intensity and complexity of protective service cases may exceed the skills and abilities of generic case managers, thereby affecting quality of services provided.

COMMENT: This was found to be true for CES. Case managers were occasionally overwhelmed by the more severe abuse/neglect cases.

2. Additional costs may be incurred in increased inservice training and supervisory time.

COMMENT: This was not found to be true for CES. No increased costs were incurred for inservice training, as no such training existed. Supervisors did not report being overburdened by supervising elder abuse/neglect cases.

3. If demand is high, time needed for these cases may detract from the regular caseload.

COMMENT: This does appear to be a danger at CES. While the number of cases requiring protective services work is small, case managers find these cases time-consuming and draining. If the demand were to increase (a probability under the new mandatory reporting legislation) case managers are likely to find it difficult to handle abuse/neglect cases in addition to their regular caseload.

(CES, continued)

PRO

COMMENT: It is not necessarily the case that these cases will be evenly distributed at CES; in fact, there is evidence that they are not. Some case managers prefer to get an abuse/neglect case. Beyond this, cases may fall more heavily in one area, thus saddling a few case managers with a disproportionate number of cases. It may be that some mechanism of insuring that cases are evenly distributed is necessary.

5. Continuity of client/case manager relationships is maintained, minimizing the number of staff with whom the client must interact around this issue.

COMMENT: This was found to be true for CES.

CON

4. Staff resistance may focus on increased individual responsibility for complex cases.

COMMENT: This did not appear to be a problem at CES. Other staff appeared very willing to collaborate on abuse/neglect cases, and individual responsibility was reduced.

5. No one person is accountable for the efficacy of protective service programs.

COMMENT: This is a problem in the CES approach. There is no quality control for dealing with abused/neglected clients. This lack of accountability makes for a wide variety of approaches to such clients, some much more effective than others.

6. Prearranged and specific service agreements are necessary to support case manager in meeting urgent needs of client.

COMMENT: Such arrangements, to our knowledge, do not exist at CES. The program would be stronger if they did exist.

7. Service poor areas may lack access to other provider agencies which have expertise in protective services for the elderly.

COMMENT: It was not possible to precisely determine if this was a problem for CES. However, the level of service integration is not as great as that in the Merrimack Valley, and services such as mental health homemakers are not available. Thus the CES program probably does suffer to a degree from being in a less service-rich environment.

EXTERNAL, CONTRACTING-OUT MODEL: Elder Services of the Merrimack Valley

PRO

1. Home care corporation will not be required to develop expertise in unfamiliar area of service provision.

COMMENT: This was found to be true for ESMV. The agency did not have a protective services specialist in-house, but relied upon the external workers.

2. Current operating structures largely unaffected, necessitating organizational adaptibility only related to referral and monitoring activities.

COMMENT: It is true that the internal operation of the agency did not need to be substantially altered to accomodate the program. However, it is not clear that sufficient moderations have been made in the area of referrals. This is shown in the lack of understanding of the protective service workers role on the part of case managers.

3. If demand is high, may be an efficient means of addressing needs of protective service caseload which will not have a negative impact on regular home care caseload.

COMMENT: This is not entirely true, for if demand is high, part-time protective service workers cannot handle it. Case managers may then receive enough cases of abuse/neglect to disrupt their normal caseload.

4. Contract provides ceiling on funds to be devoted to protective services for particular period of time.

COMMENT: This was found to be true for ESMV.

CON

1. Type and quality of protective services actually delivered will depend on the orientation and expertise of the contracting agency.

COMMENT: It was found that the ESMV model is shaped to a great extent by its location in family service agencies. This has resulted in protective service workers taking the role of short-term consultants. This is not, of course, necessarily a negative aspect of this model.

2. May prevent home care staff from developing skills in protective service client identification.

COMMENT: While our data are insufficient to show this definitively, this does not appear to have been a major problem. Case managers seem to operate quite independently in locating cases.

3. May provide incentives for home care case manager to label difficult clients as protective service clients to refer them out.

COMMENT: Our interviews did not show a great willingness on the part of case managers to refer to protective services. Instead, many maintained the difficult cases. Further, protective services does not supplant the activities of the ESMV case manager, who remains involved in the case in addition to the protective services worker.

4. May result in overcommitment of resources which are restricted for contract period.

COMMENT: No such overcommitment was found for ESMV.

(ESMV, continued)

PRO	CON
5. For the home care corporation there is only one linkage in providing protective services.	5. Evaluation and monitoring of performance is dependent on information provided by contracting agency.
COMMENT: Unfortunately, with the constraints on the protective services workers' time, other linkages need to be maintained. Often, the case manager must coordinate with Mental Health, legal services, etc. The ESMV protective services program cannot make this advantage a reality.	COMMENT: While this is true to an extent in this program, ESMV has maintained considerable involvement in the program, through regular meetings with program staff, and other informal contacts. Monitoring thus involves other information than that provided by the contracting agency.

VII. RECOMMENDATIONS AND CONCLUSIONS

In this report, the provision of protective services to abused/neglected elders by two HCCs has been detailed. The final section contains a summary of the findings, and a series of recommendations for the further development of protective services.

Summary

The basic features of two alternative models for dealing with abused/neglected clients within the HCC system were presented. One HCC, Elder Services of the Merrimack Valley, contracts out for protective services to three local Family Service Associations. Part-time protective services workers, trained at the MSW level, respond to referrals from ESMV and other community agencies. The major role of the protective services worker was found to be that of a short-term consultant to other agencies, with relatively little responsibility for long-term case coordination. Coastline Elderly Services, on the other hand, operates on standard HCC procedure in dealing with abused/neglected clients. No worker or team is designated as an abuse/neglect "specialist." Each case manager attempts to handle the abuse/neglect cases which fall into his or her caseload, with no special training or supervision.

The implementation of the EMSV program was examined, and no major problems were found in the start-up of that project. It is likely that other HCC's could contract out for protective services in a similar fashion with little disruption of agency activities. The only qualification here is the need for a strong community agency or agencies with whom to contract. ESMV was able to make use of well-established community agencies; other areas may lack such suitable contractees. As no new program was begun at CES, implementation problems could not be addressed. Two area efforts to strengthen the CES protective services function were discussed: the convening of an interagency task force, and cooperation with the local District Attorney's office. Both efforts were found to have had minimal impact on the program.

Patterns of interagency coordination were analyzed. The ESMV protective service workers appear to make maximum use of other agencies. A number of coordinative mechanisms exist in the Merrimack Valley which strengthen the protective service workers' ties to other agencies. Although there is evidence of a significant amount of informal coordination at CES, the service network appears to be less well integrated, at least in the area of elder abuse/neglect.

Finally, the replicability of the models was assessed, using comments, suggestions, and opinions of interviewees. Considerable support was expressed for the ESMV protective service workers by community agency staff. Staff at ESMV itself, however. noted some reservations about the program, which centered primarily on lack of understanding of the function of the protective services worker, and perceived lack of availability of the worker. In the New Bedford area, community agencies acknowledged that CES is making a substantial effort to handle cases of abuse/neglect in the region. Limitations on the case managers' time, however, were identified as a problem in the program, as was a need for special training in managing cases of abuse/neglect. In both programs, a number of respondents stated a preference for a protective services worker or team within the HCC.

Recommendations: CES

1. The protective services function at CES should be strengthened. It is beyond the scope of this report to suggest specific changes. CES could initiate a short-term feasibility study of various options, including designating an interested and experienced case manager or supervisor as protective services specialist, and providing him or her with additional in-service training. Other possibilities include hiring a protective services worker from outside the agency, or creating an internal team. Regardless of the specific option selected, our interviews indicate that additional resources should be devoted to protective services at CES.
2. CES should attempt to establish some kind of interagency group that would focus on issues related to the elderly. This could take the form of a small working group devoted to abuse/neglect, or a larger "Aging Network" group. A greater attempt should be made to strengthen interagency relationships.

Recommendations: ESMV

1. There appears to be some lack of understanding on the part of ESMV case managers as to the role of the protective services workers. In-service training should be carried out at ESMV to educate staff on the ways in which they might use protective services in cases of abuse/neglect.
2. The interviews revealed that although the general opinion of the protective services program is high, a number of individuals felt that a protective services unit within ESMV might be even more effective. It was not possible to resolve this question in the present evaluation. It does seem advisable for ESMV to reassess the advantages and disadvantages of

the contracting-out model. A survey could be done of ESMV and community agency staff to determine the preferences as to the location of protective services.

Recommendation: DEA

1. This evaluation strongly indicates a need for protective services for abused/neglected clients in the two areas studied. As there is no reason to believe that these areas are unique, such a need is likely to exist throughout the state. DEA should attempt to ascertain how the protective services function is currently being carried out by HCCs that, like Coastline, have no special program. DEA may, based on a survey of these HCCs, encourage the development of protective services programs. HCCs may have difficulty handing the increased demand for protective services that is likely to result from the mandatory reporting law. From this study, the option of an internal protective services specialist appears to be the strongest option for dealing with this increased demand.

EXHIBIT 3

UNIVERSITY CENTER ON AGING
UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER
SERVICES TO ABUSED ELDERS PROJECT

Boston Site Report

During the first year of the Boston Site Project, members of the Evaluation Team attended meetings of the Coordinating (later Advisory) Committee and communicated with the Project Coordinator to gather baseline information which could eventually be used to assess the effectiveness of the coordinated response system for elder abuse in Boston. This report is not intended to summarize project activities, but rather to highlight the events which demonstrate the shift in focus of the project during the year from elder abuse/neglect and the coordinated response system to protective services and legislation.

The Boston site started its career as a Model Project sub-grant with a number of problems. Initially conceived as a joint undertaking of the Commission and Legal Research and Services for the Elderly (LRSE), it had to be integrated into the Massachusetts Department of Elder Affairs (DEA) program (without LRSE) which included the Worcester site and the University of Massachusetts Medical Center Evaluation unit. This requirement of the funding agency delayed the start of the project and created difficulties in its execution. Furthermore, in order to establish a coordinated response system for the prevention and treatment of elder abuse in Boston, agencies already operating in the field would have had to relinquish some of their autonomy and territory to the Commission, which had no power to enforce participation nor any incentive to offer the agencies. In addition, surrounding the project, at least in the beginning, was a climate of mistrust and uncertainty, a result of earlier confrontations between the Commission and DEA; the private agencies and the city; and DEA and the Department of Social Services.

The Evaluation Team met with the Boston Project Coordinator in April, 1981 to discuss the Boston program, the evaluation plan and the role of the evaluators. As a result of the publicity about the Project, the Commission had begun to receive calls reporting cases of abuse and neglect, which the Project Coordinator attempted to answer and to make the appropriate referrals. He believed that a comprehensive list of resources and an intake-referral form should be prepared as soon as possible. Other early activities of the Coordinator included visits to community agencies to explain the project and participation in inservice education programs about elder abuse. His plans for the subsequent months included:

-a meeting of agencies representing health, mental health, legal and social services in a mini-conference to facilitate the development of linkages and provide representation for the Coordinating Committee;

-the development of an intake-referral form to centralize information about cases of elder abuse;

-the assessment of training needs and organization of training programs so that the project would have "something to show;" and

-the involvement of the Project in advocacy, policy-making and legislation as an incentive for agencies to accept the leadership role of the Commission.

After hearing about the Evaluation Plan for Worcester and the possible inclusion of the other Model Projects, the Project Coordinator expressed an interest in having a community survey for the Boston site and assistance from the Evaluation Team in designing the intake-referral form. On the basis of these early conversations as well as the objectives of the Project, the Evaluation Team outlined a plan for Boston which would respond to two research questions:

A. What is the nature and extent of elder abuse/neglect in the City of Boston?*

B. What is the impact of the coordinated response system on abuse/neglect cases?

The first meeting of the Boston Elder Abuse Coordinating Committee took place on July 2, 1981, and included representatives from a selected group of health, social service, and legal agencies. Following a presentation about the Project, the purpose of the Committee and the Evaluation plan, including the community survey, the group discussed the various definitions of elder abuse/neglect, the survey form, and types of intervention. The Project Coordinator announced that a revised version of the survey and a potential mailing list of recipients would be available for the Committee's consideration at the August 8 meeting. The group asked that the membership of the Committee be expanded to include other health and social service agencies involved in abuse cases.

The August 8th meeting began with another charge to the Committee for the benefit of the new members. This time, there was a greater emphasis on the legislative and policy making mission of the project than was given at the July gathering. The group continued the discussion on definitions of abuse/neglect, pointing out the need to distinguish between psychological and physical abuse and between suspected and verified cases, and the difficulty in gathering statistics. The Evaluation Team agreed to include a question on the number of cases by categories, to omit the item on self-abuse which appeared in the Worcester questionnaire, and to add one on professional abuse. Copies of the mailing list were given to Committee members so they could review it for omissions and corrections and also check off the agencies which they would be willing to contact for follow-up. Two sample intake-referral forms, one based on the experience of other hot lines and one developed by the Evaluation Team were also shown to Committee members for their comments. Other business included brief mention of training for hotline workers, and a recommendation that minority groups be represented on the Committee. Shortly before the group adjourned, the Project Coordinator announced that he would be taking on another position with the Commission and that replacement for him had been hired, but she was unable to attend the meeting.

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*The results of the survey designed to answer this question are reported elsewhere.

The Committee was reconvened on August 27th by the new Project Coordinator. The meeting began with a report on the abuse hotline scheduled to be put into operation on October 1, and training for intake workers on October 19. The sample intake-referral form was then discussed in detail, with suggestions made for improving the layout. The Evaluation Plan for the Boston Project site was distributed to the members of the Committee. In the remaining portion of the meeting, the survey which was to be mailed right after Labor Day, was discussed. The training needs assessment included with the survey was not brought to the attention of the Committee because, according to the Project Coordinator, it might cause further delay.

The following week, the Project Coordinator made a trip to Worcester to speak with the Evaluation Team. She was concerned that agencies receiving the survey would not know how to answer it. She was also troubled that some agencies have used definitions in the past which have categorized abuse as non-abuse or vice versa. The evaluators agreed to add another question to the survey which would ask about definitions presently in use by the agency although they explained that the survey had been implemented in the Worcester area with no apparent difficulty in this regard. The intake-referral form still required some attention, and she asked the Team to help with the layout.

The next Committee meeting was called for October 14. The notices which were mailed to the membership indicated that a change had been made in the name from Coordinating to Advisory Committee. Later, the Committee structure was to be divided into three sub-planning committees: Protective Services, Education and Training, and Elder Abuse Resource Coordination. The main subject for discussion that afternoon was Protective Services contracts. At the end of the session, the Project Coordinator reported that the survey had been mailed on October 5, to a list containing 395 names (subsequently found to include about 200 relevant agencies). Sixty-five responses had been received to date. She also said that the mailing list had been divided into five categories based on type of agencies and that it was her intention to convene members from each one to explain the project and to encourage early returns of the survey forms. Also, the intake-referral form was to be issued in two versions, a short one for intake workers, and a longer one for the referral agencies. The final announcement concerned the conduct of a training program for intake workers to be held on October 31-November 1.

A meeting of the health providers in the City was called by the Project Director on November 5. Most of the time was spent on describing the project activities with little attention given to completion and return of the survey forms. Meetings of the other four types of agencies never took place.

The Protective Services Planning Committee (one of the three sub-committees) met on November 12, to review the protective services for elderly in Boston and to recommend changes in the system. Included on the agenda were reports about the DSS contracts and the DEA Protective Services Task Force. Three weeks later, the sub-committee met again, this time focusing on the development of a protective services network map and definitions of protective services as well as a statement on guardianship and conservatorship.

On December 11, the entire Advisory Committee was invited to a luncheon meeting to hear Robert Biancata, legislation director for Congressman Mario

Biaggi of New York City, who had chaired the House hearings on Elder Abuse. Except for the announcement of the appointment of a new Chairperson for the Advisory Committee, no business was conducted at the meeting. The day before, the Commission had been notified that the Project would not be funded for a second year.

As noted at the beginning of the report, the implementation of the Boston project was hampered by administrative and program difficulties arising from the placement of the program under the aegis of the DEA. This change in structure and program, which delayed the start of the Project until the Spring of the year, was followed within a few months by replacement of the Project Coordinator. While the transition from one to the other was made without interruption, the new staff person brought another new style of leadership ,and focus to the project. The Coordinating Committee became an Advisory Committee organized into three sub-groups; but only one, the Protective Service Planning Committee, was activated. The other two, Education and Training, and Elder Abuse Resource Coordination which were more directly related to the objectives of the Project, never met although a second training program was in the planning stage, the survey was in progress with no follow-up procedure in place (even though Committee members had volunteered to help), and the intake-referral form was designed and needed testing.

To the credit of the Commission, the Project was able to bring together the various groups in the city involved or interested in elder abuse to discuss common issues and to begin to lay the groundwork for the coordinated response system. Although an air of mistrust and doubt existed initially, it was gradually giving way to a more trusting relationship and a growing interest in what could be accomplished by the agencies and Commission working together. The emphasis on protective services rather than elder abuse/neglect may have been necessary. As the first Project Coordinator indicated, without the ability to offer agencies some monetary reward for coordination of efforts, the Commission's only game plan may have been to assume a strong advocacy position in behalf of the protective service agencies. In so doing, however, the Project was diverted from the major objectives specified in the proposal, a strategy which, ultimately, may have contributed to its demise.

EXHIBIT 4

UNDERSTANDING DOMESTIC VIOLENCE
AGAINST THE ELDERLY

BEST COPY AVAILABLE

Karl Pillemer, M.A.
Rosalie S. Wolf, Ph.D.
University Center on Aging
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, MA 01605

Prepared for presentation at the annual meeting of the Northeast Gerontological

A considerable amount of research has been carried out in recent years in the area of domestic violence. Studies have focused in particular on the abuse of children by their parents, and the battering of women by husbands or lovers. Concurrent with this research effort has been the development of social programs to prevent these types of abuse, or to ameliorate the effects of abuse when it occurs. It is only recently, however, that academics and policy makers have turned their attention to abuse of the elderly.

Since the middle 1970's, studies of elder abuse and neglect have proliferated; these have attempted to determine the extent of the problem and to shed light on its causes (Block and Sinnott, 1979; Douglass, et. al., 1980; Lau and Kosberg, 1979; Sengstock and Liang, 1982; Wolf, et. al., 1982). This paper focuses on the latter question; What factors produce an abuse situation? Because of the purely exploratory nature of our research, we will not be able to answer this question in a definitive fashion. This paper represents a first step in understanding the complex problem of elder abuse. As such, it is hoped that it will point the way for future research.

CAUSES OF ELDER ABUSE

There have been a number of attempts to catalogue possible explanations for abuse and neglect of the elderly. Thus, Douglass, et. al. propose four possible causes. First, the normal dependencies of aging may increase vulnerability to domestic abuse or neglect. Second, the abusive behavior may result from some type of developmental deficiency; that is, through a defect in the social learning process, the child has been socialized to become abusive. A third possible cause are life crises that trigger the abusive behavior. A fourth

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*Acknowledgements: We are grateful to the staff of the Model Projects on Elder Abuse for providing the data on which this report is based, and to Beverly Giuliano for assistance in preparing the manuscript.

possibility is that environmental factors, such as quality of housing or other aspects of daily life, contribute to abusive or neglectful behavior (20).

Similarly, Sengstock and Liang use the domestic violence literature to identify three major models that explain why people abuse others. The first of these is the "psychopathological" model, which holds that abuse results from the psychological abnormality of the perpetrator. A second model emphasizes "social learning", in which the individual takes an abusive parent as a role model. Thus, abuse results not from some form of psychopathology, but from behavior patterns learned as a child. The third model cites situational stress, such as isolation, poverty, or lack of family support, as the cause of abuse.

These two efforts are examples of the most prevalent approach that has been taken thus far to understanding the causes of elder abuse and neglect: propositions derived from the literature on spouse and child abuse are directly applied to elder abuse. There is a serious problem inherent in this approach, however: it does not treat abuse of the elderly as a conceptually distinct phenomenon, but instead assumes that factors which cause child and spouse abuse will also cause abuse of the elderly. As Pedrick-Cornell and Gelles (1981) have noted, this may be a faulty assumption. It may be that there are characteristics unique to the situation of the elderly and their relationships with family members which cause abuse. Simply combining elder abuse with other types and explaining it in this fashion ignores the special character of family life in old age, with its particular strains, tensions, and dependencies.

Some researchers have attempted to go beyond the child and spouse abuse literature by basing their hypotheses on the gerontological literature regarding the family relations of the elderly. In particular, they have made use of some of the recent work on the strain of family caregiving to elderly relatives. From this research, which we will briefly review here, a general view has developed that pinpoints the increased dependency of the elderly person upon their caretakers as the precipitating factor in abuse.

Many gerontological researchers have commented upon the stress that results from caring for an impaired elderly person. Zarit, et. al. (1980) found that caretakers of elderly persons with senile dementia experienced many problems; excessive dependency on the caregiver was a major burden for family members. Archbold (1982) found that costs to caregivers included decreased freedom, lack of privacy, constant irritation, guilt, career interruptions, and financial burdens. Perhaps for reasons such as these, Fengler and Goodrich found that wives of elderly disabled men reported much lower life satisfaction than did a national sample of the elderly.

Related studies have focused specifically on the psychological and emotional aspects of caregiving. Horowitz and Schindelman (1980) found that caretakers of dependent elderly experienced increased fears about their own aging. Perhaps the most complete catalogue of the negative emotional impact of caregiving appears in a popular work by Silverstone and Hyman (1976). These authors claim that fear, anxiety, anger, hostility, and shame can strike children caring for their elderly parents.

In addition, research on services to caregivers highlights the strains of care. Safford (1980) found a great need for programs to assist families of the mentally impaired elderly. These families suffered from a "sense of anguish as they helplessly saw the physical and mental deterioration of their kin" (658).

Crossman, et. al. (1981) see supportive services as alleviating the "anger and frustration" of wives caring for disabled husbands, while Hausman (1979) emphasizes the unpreparedness of children for the dependency of their elderly parents.

Based on findings such as these, a number of researchers have assumed that the growing dependency of an elderly person increases the likelihood of abuse. Davidson, for example, ties abuse directly to the "crisis" created by the needs of an elderly parent for care. She writes:

> Yet just as the child is abused by his parent who resents the dependency of the child because the parent himself lacks satisfaction of needs, the adult child who must assume a caretaker role to his own parents may become abusive as a result of his parents' dependency and the lack of need satisfaction (49).

Steinmetz has been perhaps the major proponent of this view, arguing that families undergo "generational inversion", in which the elderly person becomes dependent upon his or her children for financial, emotional, physical, and/or mental support. This leads to severe stress on the part of the caregiver. Steinmetz asserts: "As the economic, physical, social, and emotional dependency needs of the vulnerable elderly increase, the potential for abuse increases unless adequate resources are available" (In press: 6).

In summary, efforts to explain the existence of abuse and neglect of the elderly fall largely into two basic types. The first group of researchers tends to catalogue various causes of spouse or child abuse and applies one or more of them to elder abuse and neglect. The second group provides evidence that caretakers of impaired elderly experience stress, and that this stress somehow translates itself into abuse and neglect. Although both explanations are worthy attempts at employing research findings from other areas to elderly abuse, they remain highly speculative.

As regards the first explanation, the resemblance of elder abuse and neglect to child and spouse abuse is purely hypothetical. In fact, elder abuse could differ so substantially from these other types that the child and spouse abuse literature may not be useful in understanding it. The theory that dependency breeds abuse is also speculative. Since research has shown that many elderly are quite dependent on their relatives, the question arises: Why are some of these elderly abused and others not? In light of the fact that abuse seems to appear in only a small number of cases in which relatives are caring for elderly persons, no direct correlation between dependency and abuse can be assumed (cf. Pillemer, and Wolf, 1983).

In spite of previous efforts, then, we find ourselves virtually in a theoretical vacuum. At present, the causes of elder abuse are perplexing and obscure. In order to shed light on this issue, we undertook a qualitative, exploratory study of a group of abused elderly with the specific goal of understanding possible causes of abuse. After describing the methodology employed, we construct a typology of abused elders and demonstrate the implications of this typology for further research on elder abuse. We conclude with suggestions for identifying elders with especially high risk of abuse.

METHODOLOGY

In 1980, the Administration on Aging awarded funds to three model projects to provide services to prevent and treat abuse and neglect of the elderly. These sites, based in Massachusetts, New York, and Rhode Island, offer case work services to elderly victims of maltreatment. Project staff complete detailed case assessments on clients, 184 of which have been completed to date. Although the assessment instrument contains a number of quantitative elements, a major feature of the instrument is its inclusion of opportunities for qualitative description. Site staff have expended considerable effort in describing in rich detail the history of each case, the individuals involved, and obstacles to intervening in the situation. The open-ended questions they responded to included the following:

- How would you rate the quality of the relationship between the abused/neglected client and his/her perpetrator at this time?
- Describe the major elements of the history of the interaction between abused/neglected person and perpetrator which may have contributed to the abuse/neglect situation.
- Perpetrators stated reason for abuse/neglect:
- Case-worker's assessment of reason for perpetrator's abusing/neglecting:
- Please comment on the way any barriers have been, or will be, overcome in an effort to provide necessary services in this case.

Numerous other opportunities were also provided on the assessment form for description of the case.

In the present study, a content analysis was carried out of the descriptive data on cases of verified physical abuse. This limitation was imposed for two reasons. First, physical abuse is more objectively identifiable than psychological abuse or neglect: it can be clinically verified. Second, conceptual problems result from lumping together cases of abuse with those of neglect: as Pedrick-Cornell and Gelles (1981) have noted, acts of commission differ greatly from acts of omission. Out of the 184 cases, 66 involved physical abuse; of these, 40 had sufficient qualitative responses to reconstruct the case in a detailed fashion. A simple form was developed for abstracting the major elements of each case. This provided a general overview of each abuse situation.

There are a number of obvious limitatious to such an approach. First, our sample is not representative. This difficulty is inherent in all types of qualitative research, however, and is not a serious drawback to our effort. We are not attempting to generalize our findings at some specified level of accuracy. Rather, we wish to qualitatively understand domestic violence against the elderly, and set an agenda for future research.

A more serious limitation is our reliance on case workers' descriptions of abuse. It is possible that their specialized training, concern that the project be perceived as a success, or other factors may have caused them to systematically misrepresent cases. However, we were able to compare their views of a number of cases with other professionals involved with the same clients, and found no substantial differences in the various report. Considering the lack of data in this area, the use of this type of information is clearly justified.

A TYPOLOGY OF PHYSICALLY ABUSED ELDERS

The development of typologies from qualitative data is a difficult task, and the current effort is no exception. However, our analysis of the case descriptions revealed four basic categories of abused elderly. To be sure, almost every case contained elements of more than one type; six cases, in fact, were such a mixture of different types that they were placed in a special category. The other cases fell more or less clearly into distinct groups.

A few cases (3) were grouped together because they represent long-standing patterns of family violence, which existed prior to the individual's becoming "elderly" (that is, reaching the age of 65). For example, one case involved a 65 year old woman who was abused by her daughter. The abuse situation had gone on for at least 15 years prior to the involvement of the elder abuse project. Both individuals were alcohol abusers, and the daughter had a long history of mental illness. Over the years, they had had repeated encounters with the police and were evicted several times. Thus, we see here a long-standing pattern of family disorganization and violence, unrelated to the fact that one participant has suddenly turned 65.

Another case involved an 84-year-old man who was struck by his wife. Upon investigation, it was found that the couple had fought "constantly" throughout their 35 year marriage, and that the wife struck her husband when he "(refused) to help with cleaning and dishes," a behavior which did not commence when the couple became elderly. The third case involved a woman in her mid-sixties whose boyfriend struck her whenever he was intoxicated, as he had done for the past twenty years.

A second small category (3 cases) involved those situations in which the abuser was so severely disturbed that the abuse could be attributed to the psychopathology of the abuser. One case, for example, involved an 80-year-old woman abused by her son who was in his forties. He had been in mental hospitals for extended stays and had been diagnosed as a paranoid schizophrenic. He abused drugs and alcohol, kept a small "arsenal" of guns in the home, and threatened repeatedly to kill his mother.

Another case involved a man, 73, who was abused by his schizophrenic son.

The son had struck his father in the head with a hammer a few years before and still physically abused him on occasion. The caseworker found the son be severely disturbed and virtually incoherent: he reported to the interviewer, among other things, that he wished to study biology to learn "brain control of animals." Many other cases of abuse, of course, may involve psychological or emotional problems on the part of the abuser. Only in these few cases, however, did psychopathology appear to be the primary explanation for the abuse.

The third type involved considerably more cases. These cases provide support for the assertion noted earlier that a very dependent elder is more likely to be abused. In nine of thirty-eight cases, the dependency appeared to be directly related to abuse. One case involved a couple who had been married for 53 years. The wife was extremely dependent in activities of daily living, was incontinent, whined, and demanded attention. She was confined to a wheelchair as a result of a stroke. Her husband cooked, cleaned, and cared for her by himself. The situation was made even more difficult by the fact that the wife was highly critical of the care he gave her. Whenever he reached the end of his rope, in his words, he "smacked her across the mouth." A number of cases in this category involved relationships that became abusive only after one person experienced an increase in dependency. For example, two sisters, both in their eighties, had lived together most of their adult lives. One sister experienced rapid deterioration over a two-year period and became very dependent. She was, at the time she was seen, incontinent and in need of constant supervision. She could no longer read or follow conversation, and had "spells" of acting out. Whereas the two had previously shared all household tasks, the perpetrator was forced to take on chores like cooking, which she had never done before. She struck her sister, it was reported, out of frustration.

The increase in dependency can be the "last straw" in an already unstable situation. Thus, in one case, a man and his sister lived together for over five years with no serious problems. He was a deinstitutionalized mental patient, but was able to hold a job successfully; the sister was also employed. The problems began when the sister fell, broke her hip, and developed additional health problems. Confined to her home, she became extremely dependent on her brother, following him, as he put it, "even into the bathroom". The brother reported that he felt that his stability and ability to exist outside of the institution were threatened by his sister's dependency. He feared that the strain of the situation could cause him to lose his job and be hospitalized again. As these cases show, the dependency-abuse theory finds support in some instances.

The major finding of this study, however, was in some ways counter-intuitive. While it was expected that the data would show the abused to be dependent upon the abuser, it was not anticipated that in many cases the reverse would be found. Yet in nearly one-half of the cases (17) the abuser was substantially dependent upon the abused.

This dependency takes a number of forms. Often, the abuser's need is for housing; in many cases, the abuser lives with the abused in the latter's home. This is frequently combined with financial dependency: for one of a number of reasons the abuser is unwilling or unable to be financially self-supporting. In other cases, the abuser needs the services of the abused, such as child care, cooking, or cleaning.

In some cases, the physical abuse is directly related to financial exploitation. In one case, a 67-year-old woman was abused by her alcoholic son, who was in his forties. She was in no way dependent on him (except perhaps emotionally); he, however, repeatedly requested money from her. At the time the case was referred, she had given her son $300 six days before. He had called from out of state and demanded more money. She refused, and was fearful of what he might do when he returned, as he had physically abused her before in similar situations. Another situation involved a man in his fifties who was trying to force his mother to sell her home and give him half of the proceeds. Arguments over this issue precipitated physical abuse.

While many of these seventeen cases involved some degree of financial dependency, some abusers relied on the victims for services. A 50-year-old daughter, for example, became angry and abusive towards her 86-year-old mother when the mother did not perform household maintenance activities as well as expected. In another case, the abuser was the granddaughter of a 65-year-old woman. The grandmother, who was not at all impaired, babysat for the abuser's daughter, did their laundry, and performed other services.

An interesting variation on this pattern involves situations in which the abused elder is the caregiver. One 70-year-old woman was attempting to care for her mentally and physically impaired husband. Her husband at times responded to her caregiving attempts with verbal and physical abuse. Another woman was struck in the jaw by her disabled husband as she attempted to care for him. In all of these cases, then, the abuser is substantially dependent upon the abused.*

DISCUSSION

From this study, it is apparent that physical abuse of the elderly can result from a variety of causes. For this reason, attempts to isolate a single factor responsible for elder abuse will necessarily fall short. Once such explanation is that which links the increased dependency of an elderly person to abuse. While this was found in some cases, our findings show that mutual dependency is more likely, with the abuser dependent upon the abused for certain goods or services. The question then arises: Why would the continued dependency of an adult child on elderly parent cause physical abuse?

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*An additional six cases involved a mix of the four categories. In the interest of space, these have not been discussed here.

The first possible answer to this question is a simple one: physical violence is employed to force the elderly person to comply with the abuser's demands. Thus, the use of force can simply be a tool to force an individual to give something (usually money) to the abuser. However, the case assessments indicate that these relationships are often too complex for this simple explanation. Abused and abuser are tied to one another by a long relationship which often transcends simple greed on the part of the perpetrator.

An explanation based on the family violence literature goes beyond the one just given. Finkelhor (1983), in his thoughtful attempt to identify common features of family abuse, notes that abuse can occur as a response to perceived powerlessness. Acts of abuse, he notes, "seem to be acts carried out by abusers to compensate for their perceived lack or loss of power" (19). Thus, spouse abuse has been found to be related to a sense of powerlessness, and the physical abuse of children "tends to start with a feeling of parental impotence" (19). It may be that the feeling of powerlessness of an adult child who is still dependent on an elderly parent experiences is especially acute, because it goes against society's expectations of normal adult behavior.

Thus, one reason why some persons abuse elderly relatives may be to achieve a specific result, such as obtaining money. Alternatively, the reason may be a psychological one: the individual perceives a power deficit, and seeks to restore power (Finkelhor, 1983: 19). Both of these explanations deserve further exploration.

IMPLICATIONS FOR ELDER ABUSE PROGRAMING

Many states are developing protective service programs to deal with abused and neglected elders. In addition, some states (most recently Massachusetts) have instituted mandatory reporting laws. In order to implement such laws, the protective services function must be expanded even further. A dilemma facing every new program is that of case-finding: who are the most vulnerable elderly? If our findings are substantiated by other research, the characteristics of the elderly at greatest risk of physical abuse can be identified.

First, abused elderly are likely to live with others; numerous other studies have found this as well. While it would be a logical fallacy to assert the inverse proposition—that all old people who live with others are likely to be abused—certainly those living alone appear to have a lower risk of physical abuse. Based on the findings reported here, a situation in which relatives (especially children) live as dependents with an older person would be especially worthy of monitoring for potential abuse.

Much programing energy is currently being directed towards families in which the elderly person lives as a dependent. Based on the hypothesis that dependency leads to abuse, supportive services to caregivers, such as self-help groups, have been offered. While such programs may play a role in forestalling or preventing abuse, our research shows a need for other types of services: those directed toward abusers who, for a variety of reasons, remain unhealthily dependent upon an aged parent. These could include psychotherapy, employment counseling, and financial support while establishing an independent household. Abusers may need concrete help to break the bonds of dependency.

Clark and Anderson (1967) have insightfully described the ideal relationship between elderly parent and adult child in a way that is extremely applicable to our discussion here. It is worth quoting those authors at length:

> It would appear that, in our culture, there simply cannot be any happy role reversals between the generations, neither an increasing dependency of parent upon child, nor a continuing reliance of child upon parent. The mores do not sanction it and children and parents resent it. The parent must remain strong and independent. If personal resources fail, the conflicts arise. The child, on the other hand, must not threaten the security of the parent with requests for monetary aid or other care when parental income has shrunk through retirement. The ideal situation is when both parent and child are functioning well. The parent does not depend on the child for nurturance or social interaction; these needs the parent can manage to fulfill by himself elsewhere...The child establishes an independent dwelling, sustains his own family, and achieves a measure of the hope the parent had entertained for him (275-276).

This view, we believe, is correct in stressing the reciprocal nature of dependency. Dependence of parent on child in later life is not the only, or perhaps even the main cause of elder abuse. Instead, continued dependence of children on aged parents may be a more powerful predictor of domestic violence against the elderly.

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EXHIBIT 5

UNIVERSITY CENTER · ON AGING ·

University of Massachusetts
Amherst, Boston & Worcester

and the

Massachusetts Department of Elder Affairs

present a

TRAINING PROGRAM
FOR PROTECTIVE SERVICE WORKERS

January 10-11, 1984

Holiday Inn
Dedham, Massachusetts

January 17-18, 1984

Yankee Drummer Inn
Auburn, Massachusetts

supported by a Title IV-C grant from the Administration on Aging to the Massachusetts Department of Elder Affairs

PROGRAM INSTRUCTOR

Thelma Baily, M.S.W.
Peasefield Associates
Limerick, Maine

GUEST INSTRUCTOR

Susan W. Graefe, M.S.W.
Family Institute of Rhode Island
Pawtucket, Rhode Island

GUEST SPEAKERS

Cynthia Collins
Public Service Director
WBZ-TV
Boston, Massachusetts

Michael Donnelly
Assistant District Attorney
Worcester County

Tony Pellegrini
Project Director
Victim/Witness Assistance Project
Worcester County

PROGRAM COORDINATORS

Kent Boynton, Ph.D.
Project Director
Services to Abused Elders
Massachusetts Department of Elder Affairs

Ann Marchetta
Regional Supervisor
Protective Services Program
Massachusetts Department of Elder Affairs

Rosalie S. Wolf, Ph.D.
Associate Director
University Center on Aging
University of Massachusetts Medical Center
Worcester, Massachusetts

PROGRAM SCHEDULE

TUESDAY, JANUARY 17

9:00 am	*Registration*
9:15 am	*Welcome*
9:20 am	The Role of the Protective Service Worker
	Identification of the Abused Client
12:00 pm	*Lunch*
	Group Assignments
1:00 pm	Principles and Dilemmas of Practice
4:00 pm	*Adjourn until Wednesday morning*

WEDNESDAY, JANUARY 18

9:00 pm	Special Problems Facing the Protective Service Worker
12:00 pm	*Lunch*
	The Elderly Victim and Services Available Through the Court System
1:00 pm	The Service Plan
4:00 pm	*Adjournment*

Exhibit 6

ELDER ABUSE TRAINING CONFERENCE

SYRACUSE

EVALUATION

March 1982
University Center on Aging
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, Massachusetts 01605

ELDER ABUSE TRAINING CONFERENCE
EVALUATION

INTRODUCTION

The Elderly Abuse Conference, sponsored by the Elder Abuse Program/Alliance/Catholic Charities, a project funded through the Metropolitan Commission on Aging, was held at Hutchings Auditorium, Syracuse on Monday January 18 from 9 a.m. to 4 p.m. It was designed for participants from social services, health services, home care agencies, senior centers, church groups and voluntary organizations. Its goal was to enable participants to understand elder abuse, to help in its prevention, and to alleviate the consequences of abuse and neglect. The main presenter for the program was Warren Dahlin, Director of Elderly Services of the Brockton, Massachusetts Area Multi-Services Inc, assisted by Millie Cleinman. According to Warren Dahlin's objectives, learners would gain some knowledge of causes of abuse, be able to identify several therapeutic approaches to cases of abuse, learn to utilize professional and informal support systems, gain awaremess of the visceral response to elder abuse and of the importance of establishing a non-punitive atmosphere when intervening in cases of abuse.

The program was attended by 150 people. Because it was expected that some participants might not remain for the entire day, separate evaluation sheets were made for the morning and the afternoon program.

MORNING SESSION

Ninety-six evaluation forms were returned for the morning. Respondents came from the following types of organizations (Table 1):

Table 1 Responses by Type of Organization

Organization	# of responses
Social Services	31
Home Care Agencies	20
Senior Clubs/Centers	9
Health Services	8
Other	
Mental Health Services	5
AAA	5
Housing Services	3
Alliance	2
Nursing Homes	2
Voluntary Organizations	2
University Gerontology Center	2
Other (outreach, ombudsman legislative aide victim services 3 unmarked)	7
TOTAL	96

Information according to position was simplified for analysis to two categories: administrator/supervisor (19 Rs), and direct service (46 Rs). The remainder (19 Rs) represented such positions as planner, faculty, student, volunteer, or no answer. Almost half the respondents were in direct service which was the largest category.

The first part of the morning included the presentation of a case of elder abuse by role playing between Warren and Millie, later joined by a son chosen from the audience, and followed by a discussion of the case and its presentation. Asked how frequent they thought cases such as that portrayed by Millie might be, the majority estimate was "fairly frequent (58%), frequent (29%), and exceptional (3%).

Eighty-seven respondents considered such a case presentation to be a good learning experience. Some comments made supporting this answer related to the characteristics presented by the case: it included some of the classical symptoms of abuse such as continuation of abuse patterns from one generation to the next (3 Rs), and the victim's expectation of abuse (2 Rs); it illustrated most effectively some of the family dynamics leading to abuse (8 Rs); the role playing that followed with the sone presented both sides of the situation (7 Rs); it gave a solid definition of elder abuse (1 R). Other positive comments centered on this type of case presentation as good teaching strategy: getting people's attention right away, getting them involved (3 Rs), particularly at a feeling level (5 Rs); making the audience identify with and experience the reality 3 Rs); stimulating thinking and questioning (4 Rs). Two respondents added that Millie's acting was terrific.

Three forms gave no answer; one wrote that it was "fairly good" learning experience; five responses were negative. Accompanying comments were as follows: the role playing was long and tedious and failed to provide information and answers to the problem (2 Rs); the interviewing techniques were bad and therefore did not present a positive model for learning; the therapist lacked in respect towards the client, and the whole session was voyeuristic and offensive (1 R); role playing is not authentic and therefore nothing can be learned from it (1 R); the case presented focused on the more sensational aspects of elder abuse, actual battery of the victim, whereas the more prevalent form of abuse is neglect and psychological abuse which attacks the dignity and self worth of the individual (1 R).

Participants were asked if the role playing that included the mother and son had influenced their understanding of the situation. 29 percent said it had not changed their view of the situation; 39 percent found it had increased their sympathy for the son, 26 percent had become more sympathetic to both mother and son; 6 percent became more sympathetic to the mother. Some of the comments quoted earlier related to the value of this part of the presentation as increasing awareness of the complexities of family dynamics.

Asked how much they had learned from the role playing presentation and ensuing discussion, answers varied somewhat according to respondent's position and organizational affilitation (see tables 2 and 3).

Table 2: Respondents Evaluation of New Understanding Gained by Area of Learning and The Position of Respondent

Area of Learning	Administrator/ Supervisor	Direct Service	Others
Events leading to abuse	29 (72%)*	37 (54%)*	10 (71)*
Ways of bringing help	19 (66%)	24 (60%)	12 (71%)
Ways not to bring help	13 (50%)	16 (43%)	6 (36%)
Problems of trying to help	23 (82%)	18 (58%)	11 (78%)

*% are based on number of respondents for that category

Table 3: Respondent Evaluation of Learning: New Understanding Gained by Area of Learning and Organizational Affiliation of Respondent

Area of Learning	Social Service	Home Care	Senior Centers	Health Services	Other
Events leading to abuse	12(50%)*	11(69%)*	6(75%)*	6(85%)*	17(65%)*
Ways of bringing help	17(57%)	12(70%)	8(100%)	4(50%)	13(52%)
Ways not to bring help	8(38%)	9(60%)	5(71%)	1(20%)	12(57%)
Problems of helping	15(53%)	16(89%)	7(88%)	7(110%)	19(79%)

(*% based on number of respondents for that category)

Although on most items the majority of respondents in the direct service category considered they had gained new understanding from the presentation, their percentage was considerably lower than those not in direct service:- administrators/supervisors and others. It would seem that direct service exposure made some of the materials presented more familiar to them than to those somewhat removed from client situations. Considering responses by organizational affiliations, although a majority of respondents from social services answered positively on three of the four items, they were less likely to consider they had learned something new than those from other organizations.

Warren (acting as therapist) had commented negatively on his therapeutic approach. A slight majority of respondents expressed dislike for the therapist's approach (45 disliked, 42 liked his approach). Positive replies were more likely to come from the non-direct service respondents: to administrators/supervisors were favorable 16 to 14, 8 to 7 of the others were favorable). Respondents in direct service expressed disapproval 24 to 18.

Remarks favorable to his approach were: He was very concerned, sincere, accepting, non-threatening (10 Rs); he was good at probing, getting Millie to tell her story (2 Rs); his approach was unrealistic but legitimate for the requirements of the role playing presentation (7 Rs). Some negative comments related to his lack of indepth exploration of the problem in the therapy session: he did not seek to help Millie gain insight, explore her feelings (3 Rs); he failed to give her feedback (2 Rs); he should have been more confrontive (2 Rs); he was too aggressive, put her on the spot, was too frank (2 Rs); he was not supportive enough, and could have emphasized Millie's strong points more (2 Rs). According to other comments: he was cold, artificial (1 R); he asked too many questions (3 Rs), gave his opinion too much (1), did not allow Millie to talk enough (4 Rs). One felt he was biased in favor of Millie, another that he patronized her. Two considered this exchange was not appropriate for public view. These comments are very contradictory reflecting the ambiguity involved in simulating a therapeutic session of this nature in front of a large and diverse audience, and the different therapeutic styles favored by the participants.

Participants rated the discussion following the case presentation and role playing on a scale of 1-4 (1=excellent, 2=good, 3=fair, 4=poor) as follows (Table 4):

Table 4 Respondents' Rating of Discussion

Opportunity for asking questions	1.28
Opportunity for sharing	1.99
Answers met the needs of participants	1.79

Ratings fell in the good to excellent category. Five respondents commented that neither the time frame nor the size of the audience would have allowed for more effective sharing opportunities, this confirming the satisfaction of the participants considering the limitations of the situation.

During the second part of the morning a brief presentation was made by Millie concerning the importance of community organizing and public awareness, followed by a longer presentation by Warren concerning causes of elder abuse, based on research findings and on his own experience in this field. There was considerable confusion among the respondents about Millie's presentation. Thirty-four out of 83 who responded to a question concerning its relevancy to them rated it as very relevant, 41 as somewhat relevant, 8 as not at all relevant. Comments made by 19 of those who considered it very relevant showed that their response was addressed to her acting and participation in the discussion that followed which they confused with her presentation. Positive comments related to her emphasis on the value of enlisting community support (2 Rs), making use of public relations (1 R), of the media (2 R); the need to respect the community, to make optimal use of available community resources. Three appreciated her remarks concerning the need to provide supervision and direction for volunteers. Negative comments were that her presentation was vague, respondents were not sure what it was about or could not follow it, that it was too speedy and confused.

Questions relating to Warren's presentation on causes of abuse intended to assess how clearly certain points made in the presentation had been understood by the participants. The lecture stressed that little is known about elder abuse and that more research is needed. 89 of the 96 respondents answered this question correctly. The point was made that research results are often confused and contradictory: 81 of 96 answered this question correctly. It was pointed out that researchers were evenly divided on their assessment of male versus female as the most frequent perpetrators of elder abuse. Respondents were asked if the abuser is most often male: 46 answered affirmatively, two specified it was evenly divided, 36 answered negatively. Although a negative answer was the correct one, this question may have been confusing since the experts are divided on this point.

Respondents were asked to rate the relative frequency of a suggested list of causes of abuse. Answers were given the following values: very frequent = 3, frequent = 2, rarely = 1, never = 0. Results are listed in Table 5.

Table 5. Estimate by Respondents of Relative Frequency of Causes of Elder Abuse

Causes	Frequency of Ratings
strains of caretaking	243
dependency of victim on abuser	232
alcoholism	231
psychological problems of abuser	231
socio-economic stress	223
psychological problems of the victim	210
dependency of abuser on victim	215
outside circumstances (bereavement, divorce, move...)	198
role reversal between victim and abuser	196
drug abuse	188
organic-physical problem of abuser	171

It is difficult to assess how much these responses reflect the information received or the previous knowledge of the participants. The lecture emphasized stress as cause number one. Special mention was also made of alcoholism and low self image of the abused. If the onset of abuse was sudden and unexpected, participants were told that organic discontrol syndrome might be suspected and a neurology exam recommended. Role reversal was mentioned as contributing to stress of the abuser. Drug use by the abuser was not discussed but the inappropriate use of drugs by the victim was described as one possible form of abuse.

Participants were asked what other areas relating to elder abuse they might have wished to hear discussed. Three areas were mentioned which were not intended to be addressed by the conference: self neglect (8 Rs.), institutional abuse (5 Rs), and professional abuse (2 Rs). Respondent also asked for more discussion of neglect (6 Rs), psychological-verbal abuse (4 Rs), financial (4 Rs). It is true that the abuse cases discussed, although they had other components, were for the most part clearly cases of physical abuse, and little attention was given to these other more frequent and less easily defined forms of abuse. More information was requested about research findings and about actual cases (4 Rs), in particular about characteristics of abusers, about abuse perpetrated by other than grown children such as spouses, other relatives, friends and other elderly (3 Rs). A need was also expressed for discussion of treatment of abuse (6 Rs), case finding, access and protocol (5 Rs), legal issues (2 Rs) and development of support groups (2 Rs).

Components of the morning program listed as most useful fell into the following categories: case presentation, role playing, discussion, lecture, and community organization presentation. Scores were established by assigning a value of 3 to those items listed first, 2 to those listed second, and 1 to those listed third. A breakdown of the responses is given according to position of respondent in Table 6 and according to respondents' agency in Table 7.

Table 6: Program Components Rated as Most Useful According to Position of Respondents.

Program Components	Administrators/ Supervisors	Direct Service	Other	Total (all combined)
Case presentation	28	31	8	67
Role Playing	43	54	23	121
Discussion	29	29	8	66
Lecture	18	49	13	80
Community Organization	14	4	1	19

Table 7: Program Components Rated as Most Useful According to Agency Affiliation

Program Components	Social Services	Home Care	Senior Centers	Health Services	Other	Total
Case presentation	21	11	7	6	22	67
Role Playing	30	26	14	10	41	121
Discussion	11	15	13	8	19	66
Lecture	24	24	4	4	24	80
Community organization	8	7	0	3	1	19

Role playing was the most appreciated part of the program. Since the case presentation was also a form of role playing, some of the enthusiasm for this initial part of the program may have been labelled role playing. The lecture was generally ranked second, though some differences can be noted between categories: direct care providers considered it a close second, and so did respondents from social services and home care agencies. For administrators/ supervisors, the lecture only came fourth in order of preference. This was also true of respondents from senior centers and health services.

Five answered the question relating to parts of the morning that were not useful: two listed Millie's presentation, and three the role playing.

AFTERNOON SESSION

Plans for the afternoon program were somewhat modified to accomodate further aspects of Warren's presentation which he did not have time to include in the morning. This material was not covered in the evaluation form for the afternoon. The discussion of the protocol was omitted because of lack of time, and thus that question on the evaluation form was dropped.

Approximately two thirds of the morning participants were present in the afternoon. Seventy-nine completed the evaluation forms. Of these 74 said they had attended the morning program. The composition of the audience in the afternoon was roughly the same as in the morning, though with a fairly high attrition of those from home care agencies (20 in the morning, 11 in the afternoon completed evaluation forms). Direct service workers also were reduced from 46 in the morning to 37 in the afternoon. Other categories remained almost identical.

Concerning the clarity of the instruction for the afternoon workshop, 60 responded affirmatively. Participants were asked to rate the workshop discussion on a scale of 1-4 (1=excellent; 2=good; 3=fair; and 4=poor) in terms of the effectiveness of teamwork, participation of the individuals, learning from others and learning from the group process. (See Table 8).

Table 8: Rating of the Workshop Discussion

Effectiveness of teamwork	1.9
Participation of individuals	1.7
Learning from others	1.9
Learning from the group process	2.0

For each of the components, the rating was either "good" or a little higher than "good". (When these ratings were grouped by organization type, the results were the same. It did not matter whether the person was affiliated with a social service, health organization, home care agency, or senior center). Thirty seven of the 79 individuals in attendance answered the question, "Were there any problems encountered in the functioning of your group?"; however 8 of these responded by saying "no problem". The difficulties most often cited by the 29 others were uneven participation by members of the group and lack of information (5 and 4 persons, respectively).

When asked to rate the plenary discussion of the case (1=excellent, 2=good, 3=fair, and 4=poor), the responses of the group mirrored those of Table 8 (See Table 9). The ratings for each component are slightly better than "good."

Table 9: Rating of the Plenary Discussion of the [illegible]

Learning from other groups	1.8
Learning from presenters	1.8
Suggestions of methods of intervention	1.8
Discussion format	1.9

In response to the question as to which part of the afternoon program was most useful in order of importance, the participants generally chose the workshops. The results are given below, grouped by position (direct service providers, administrators–supervisors, and others). The answers which were considered the most important were given a value of 3, those next in importance, 2, and those third on the list, 1.

Table 10: Part of the Afternoon Program Most Useful

	Direct Service	Administrators Supervisors	Others
Warren's lecture/research findings	20	17	24
Case presentation and instructions	3	3	3
Workgroup and group discussion	34	39	37
Report of Workgroups	18	20	10
Questions and final discussion	4	7	7

There seems to be little difference between categories of respondents except that, as in the morning, direct service workers expressed greater appreciation for the lecture presentation than administrators/supervisors.

OVERALL EVALUATION OF THE PROGRAM

Participants were asked to give an overall rating of both the morning and afternoon programs regarding some general aspects of the conference. These responses are presented in Table 11. Ratings for both parts of the day are very similar, with a slight decline in enthusiasm in the afternoon. This could be the result of a certain natural weariness, but might also reflect the impossibility of maintaining the level of attention and intensity obtained through the dramatic role playing in the morning.

Table 11: Overall Ratings of The Conference

Program aspects	Ratings AM	 PM
Speakers	1.2	1.3
Content of Program	1.4	1.6
Style of Presentation	1.6	1.7
Use of Time	1.9	1.7
Organization	1.8	1.9
Physical Facilities	1.5	1.8

Comments relating to these aspects of the program were as follows. Concerning the speakers: Warren was excellent, Millie was fair (1 R). Concerning the presentations, their content and style, several wished for tighter, more organized presentations, more concrete information, better overviews, more positive models of intervention. Requests for discussion of legal and ethical aspects were voiced twice during the conference and expressed in both morning and afternoon evaluations. Concerning physical facilities, 3 mentioned the lack of restroom and hall space, and 1 objected to transferring to another building for the workshops in the afternoon. In the morning evaluations, 3 wrote: "excellent program", and one added: "unique and stimulating." In the afternoon, 1 wrote across the top of the form: "One of the best conferences I have ever attended."

The conference was, as reflected by the evaluations of the respondents, a great success. It fulfilled its goals in that it raised community awareness, brought participants in closer contact with the realities of elder abuse and provided them with some information about causes of abuse and efforts to intervene. In one day and with a large and diverse audience, there are limitations to what can be accomplished. Certain suggestions of the participants may be helpful as indicators of what is most needed in the future. It seems that the needs for information and training of direct service workers differ somewhat from those in other categories. They seemed to appreciate most the factual information given and demand more concerning facts of elder abuse, concrete cases, protocols and positive models of intervention in the treatment of elder abuse. A need for discussion of various types of abuse other than physical was expressed. Before this can be addressed, it seems that definitions of elder abuse must be clarified so that self abuse and neglect can be distinguished from domestic forms of elder abuse. Related to these differences are ethical and legal issues which were not addressed in the conference and were certainly of concern to the participants. The model of the afternoon workshops could perhaps be improved by specifying more clearly the tasks of the group, especially including the need to devise means for getting further information. Participants complained of the lack of information about the case being discussed, yet the groups for the most part did not address themselves to how such information could be obtained. Workshop participants could usefully be chosen so as to represent different professional expertise. The demand for a positive model could perhaps be met by a simulated case conference between different professionals having had experience in the area of abuse. These suggestions and ideas concerning new programs are a valuable contribution of this conference to further training in elder abuse.

ELDER ABUSE CONFERENCE

Sponsored by the Elder Abuse Program/ALLIANCE/Catholic Charities, a model demonstration project funded through the Metropolitan Commission on Aging

Monday, January 18, 1982 9:00 a.m. - 4:00 p.m.

Hutchings Auditorium
810 E. Genesee Street
Syracuse, N.Y. 13210

9:05 a.m. Welcome - Axilda Chadwick, Chairperson, Elder Abuse Advisory Board.

9:10 a.m. Introduction of speaker - Roslyn Bilford, Executive Director, Metropolitan Commission on Aging

Facilitator - Pat Cridland, Director, Elder Abuse Program

9:15 a.m. Main Presenter - Warren F. Dahlin, Jr., M.S. OTR, Director of Elderly Services, Brockton Area Multi-Services, Inc., funded by Department of Mental Health, Commonwealth of Massachusetts. Clinical faculty member Tufts University, Boston University, and University of New Hampshire. National lecturer who has produced an hour long documentary of elder abuse.

10:30 - 11:00 a.m. Coffee break

11:00 - 12:00 Presenters' discussion of etiology, dynamics, treatment of elder abuse

12:00 - 1:00 p.m. Lunch

1:30 p.m. Reconvene Hutchings Auditorium. Case presentation.

1:45 p.m. Small groups. Hutchings Training Building. (building with green doors, next to cafeteria.)

2:30 - 4:00 p.m. Reconvene at Auditorium for Case Summarizations, Service Protocol Exercise and Conference Conclusion.

EVALUATION

ELDER ABUSE CONFERENCE

MORNING PROGRAM

Please provide the following information concerning your organizational affiliation and position:

TYPE OF ORGANIZATION

Social Services ____
Health Services ____
Church Groups ____
Senior Clubs/Centers ____
Voluntary Organization ____
Home Care Agency ____
Other ____

TYPE OF POSITION

Administrator/Director ____
Supervisor ____
Direct Service ____
Board Member ____
Volunteer/Participant ____
Other ____

PRESENTATION OF THE CASE: THERAPIST AND MILLY

Do you feel this kind of case is
___ exceptional
___ fairly frequent
___ very frequent

Do you feel this kind of case presentation is a good learning experience?
yes ___ no ___ In what way?

ROLE PLAYING BETWEEN MOTHER AND SON

How did this role playing affect your understanding of the situation?

Increased sympathy for mother? _____

Increased sympathy for son? _____

Did not change your view of the situation? _____

DISCUSSION OF THE ROLE PLAYING

How would you rate what you learned about the following?

	gained new understanding	learned nothing new	disagreed conclusio
Events likely to lead to abuse			
Ways of bringing help			
Ways not to bring help			
Problems of trying to help			

Did you like the therapist's approach to Milly? yes ___ no ___

Please comment:

BEST COPY AVAILABLE

How would you rate the discussion format:

	excellent	good	fair	poor
. provided opportunities for questions	1	2	3	4
. provided opportunities for sharing	1	2	3	4
. answers given met the needs of the participants	1	2	3	4

Suggestions for improving such a format:

MILLY'S PRESENTATION: ROLE OF COMMUNITY ORGANIZER AND PUBLIC AWARENESS PERSON

How relevant was this presentation to you? very ___ somewhat ___ not at all

If relevant, what part of the presentation did you find most useful?

PRESENTATION ON RESEARCH FINDINGS CONCERNING ELDER ABUSE

- Which of the following statements do you feel describes the present state of research:

- a great deal is known about cases of elder abuse	T F
- information about elder abuse is unclear and contradictory	T F
- research indicates that men are most often the abusers	T F

What other areas of elder abuse would you wish to have heard discussed?

o Among possible causes of elder abuse, how do you rate the following?

Causes	very frequent	frequent	rarely	ne
organic-physical problem of abuser	1	2	3	
psychological problem of abuser	1	2	3	
psychological problem of victim	1	2	3	
socio-economic stress	1	2	3	
role reversal between victim and abuser	1	2	3	
dependency of the victim on abuser	1	2	3	
dependency of abuser on victim	1	2	3	
alcoholism	1	2	3	
drug abuse	1	2	3	
past relationship between victim and abuser	1	2	3	
strains of caretaking	1	2	3	
outside circumstances (bereavement, divorce, move, etc.)	1	2	3	
other (specify) ____________	1	2	3	

WHICH PART OF THE MORNING PRESENTATION DID YOU FIND MOST USEFUL TO YOU IN ORDER OF IMPORTANCE:

1.

2.

3.

Which were not useful?

o Among possible causes of elder abuse, how do you rate the following?

Causes	very frequent	frequent	rarely	never
organic-physical problem of abuser	1	2	3	4
psychological problem of abuser	1	2	3	4
psychological problem of victim	1	2	3	4
socio-economic stress	1	2	3	4
role reversal between victim and abuser	1	2	3	4
dependency of the victim on abuser	1	2	3	4
dependency of abuser on victim	1	2	3	4
alcoholism	1	2	3	4
drug abuse	1	2	3	4
past relationship between victim and abuser	1	2	3	4
strains of caretaking	1	2	3	4
outside circumstances (bereavement, divorce, move, etc.)	1	2	3	4
other (specify) ____________________	1	2	3	4

WHICH PART OF THE MORNING PRESENTATION DID YOU FIND MOST USEFUL TO YOU IN ORDER OF IMPORTANCE:

1.

2.

3.

Which were not useful?

OVERALL RATING OF THE MORNING PROGRAM

	Excellent	Good	Fair	Poor
Speakers	1	2	3	4
Content	1	2	3	4
Style of presentation	1	2	3	4
Use of time	1	2	3	4
Organization	1	2	3	4
Physical facilities	1	2	3	4

Please fill out this evaluation before leaving the morning program. If this is impossible, please return it to:

Patricia Cridland
Elder Abuse Project
Alliance
1654 W. Onondaga Street
Syracuse, NY 13204

Thank you. Your opinion is greatly valued.

EVALUATION

ELDER ABUSE CONFERENCE

AFTERNOON PROGRAM

Please provide the following information concerning your organizational affiliation and position:

TYPE OF ORGANIZATION

Social Services ____
Health Services ____
Church Groups ____
Senior Clubs/Centers ____
Voluntary Organization ____
Home Care Agencies ____
Other ____

TYPE OF POSITION

Administrator/Director ____
Supervisor ____
Direct Service ____
Board Member ____
Volunteer/Participant ____
Other ____

Did you attend the morning session? Yes ____ No ____

INSTRUCTIONS CONCERNING AFTERNOON WORKSHOPS:

Did instructions explain clearly what was to be done in workshops?
Yes ____ No ____

WORKSHOP DISCUSSION

How would you rate the following?	excellent	good	fair	poor
. Effectiveness of teamwork	1	2	3	4
. Participation of individuals	1	2	3	4
. Learning from others	1	2	3	4
. Learning from the group process	1	2	3	4

Were there any problems encountered in the functioning of your group?

PLENARY DISCUSSION OF THE CASE

How would you rate the following?	Excellent	Good	Fair	Poor
. Learning from other groups	1	2	3	4
. Learning from presenters	1	2	3	4
. Suggestions of methods of intervention	1	2	3	4
. Discussion format	1	2	3	4

DISCUSSION OF THE PROTOCOL

How would you rate the following?	very useful	useful	irrelevant
drawing up own information sheet	1	2	3
discussion of information to be obtained	1	2	3
suggestions of how to obtain information	1	2	3
handout of elder abuse profile	1	2	3

WHICH PART OF THE AFTERNOON PROGRAM DID YOU FIND MOST USEFUL IN ORDER OF IMPORTANCE:

1.

2.

3.

Which were not useful?

OVERALL RATING OF THE AFTERNOON PROGRAM

	Excellent	Good	Fair	Poor
Speakers	1	2	3	4
Content of program	1	2	3	4
Style of presentation	1	2	3	4
Use of time	1	2	3	4
Organization	1	2	3	4
Physical facilities	1	2	3	4

SUGGESTIONS FOR FUTURE INFORMATIONAL PROGRAMS:

PLEASE FILL OUT THIS EVALUATION BEFORE LEAVING! If this is not possible, please return it to:
Patricia Cridland
Elder Abuse Project, Alliance, 1654 W. Onondaga St.
Syracuse, NY 13204

EXHIBIT 7

THE CONSEQUENCES OF JUDGMENTAL IMPAIRMENT AMONG THE ELDERLY IN HEALTH CARE

Some Thoughts on Theory and Intervention Regarding Elder Abuse and Neglect

Rosalie S. Wolf, Ph.D.
Associate Director
University Center on Aging
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, Massachusetts 01605

Karl A. Pillemer
Research Associate
University Center on Aging
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, Massachusetts 01605

Presented at "The Judgmentally Impaired Elderly: Issues of Abuse and Victimization", Brookdale Institute on Aging and Adult Development, Columbia University, New York, New York, May 10, 1984.

Introduction

Six years ago, a University of Delaware sociologist, testifying on family violence before a House Sub-Committee, startled the audience and the nation with a report on "battered parents" (Steinmetz, 1978). Although the initial reaction was one of disbelief and righteous indignation, studies conducted in the two years following showed that elder abuse was occurring nationwide and that its incidence was rising. It was also evident from these initial findings that some community agencies were unaware of the problem or denied its existence. Causes of agency non-recognition were attributed to the hidden character of the phenomenon, the reluctance of the victims to report, the fear of legal action, the tendency of the practitioners to focus on obvious factors or only those germane to their professional specializations, and lack of knowledge.

In response to the aroused interest of the public and the Congress, the Administration on Aging allocated a portion of its 1980 discretionary funds to support several Model Projects. Their objectives were to determine the nature and extent of the problem and to demonstrate improved methods of intervention and prevention. The findings presented here are taken from an evaluation of the three Model Projects on Elderly Abuse.* Data were collected on 127 cases reported by community agencies in two cities in Massachusetts over a six month time span and 328 cases seen by the three Model Projects in a two year period as well as 50 non-abuse cases selected as a comparison group from the case load of one of the Model Projects. The study was limited to victimization of persons 60 years and older living in domestic settings which involve family members, neighbors, or other persons who assume the role of care-giver. It excluded cases in institutional settings or those which might result from professional or societal attitudes or behaviors.

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*Grants for Model Projects on Elderly Abuse were awarded by the Administration on Aging to the Massachusetts Department of Elder Affairs which contracted with Elder Home Care Service of Worcester Area, Inc. to carry out the demonstration; the Metropolitan Commission on Aging of Onondaga County, New York which contracted with Alliance Division of Catholic Charities of Syracuse; and the Rhode Island Department of Elderly Affairs which operated the demonstration project form the state office.

This presentation begins with a brief report of the historical development of interest in the problem of elder abuse and neglect followed by a discussion of some of the major theoretical explanations which have been proposed by researchers in the fields of aging and family violence and a short description of the organizational models for intervention. It ends with a few words about some of the conflicts which face practitioners in this field. References will be made to the findings from the Model Project evaluation to underscore the theoretical arguments.

Historical Background

The development of serious academic interest in child and spouse abuse during the sixties and seventies and the growing concern regarding the problems of the aged in America are two factors important in understanding the recent interest in elder abuse. Although child abuse has been present for much of recorded history, and attempts to prevent it in this country go back to the 1880's, it was not until Kempe and associates (1962) produced the classic study of the "battered child syndrome" that attention was focused on this horrifying problem. The mobilization of effort to combat child abuse which followed was monumental. By 1968, all fifty states had implemented legislation mandating the reporting of child abuse, and providing protective services. It is important to note that child abuse was "discovered" by professionals and attempts to solve this problem have largely originated and have been managed by the medical, legal, and social work professions.

Such was not the case with battered women. The development of programs in the area of spouse abuse have been tied instead to the feminist movement and has, in large part, existed outside the formal service network. Unlike abused children, who quickly found champions in the legal community, throughout the 1960s and 1970s, battered women encountered what has been termed "a grim tale of judicial and police non-response" (Myers, 1980). Work by feminists has helped to focus public attention on the problem, as have publications by others in the women's movement.

Thus, two very different examples of the "discovery" of a type of abuse and its consequent labeling as a social problem exist. Elder abuse appears to fit the child abuse pattern most closely. While some grassroots advocates for the elderly have highlighted the problem, formal service agencies and professionals have been quick to monopolize the issue. In fact, Callahan (1981) raises the possibility that elder abuse programs have been developed "because there is a supply of professionals looking for new markets, resources in search of needs".

Within less than a ten year period, mandatory reporting laws for elder abuse have been passed in thirty two states. Federal legislation to establish a National Center on Elder Abuse and to provide financial assistance for programs of prevention, identification, and treatment has been filed in the past two Congresses. Although approved by the House this year, chances of enactment are slim because of less interest on the Senate side.

Theories of Elder Abuse and Neglect

Any attempt to understand the dynamics of abuse situations must take into account theory and research relating specifically to the aged. It must be asked: What is it that makes the elderly vulnerable to abuse? How does being old specifically pattern family violence? In reviewing the sociological and psychological literature on spouse and child abuse and gerontological research on family relations of the elderly, several areas emerge as possible explanations of elder abuse. They will be discussed briefly.

Intra-individual Dynamics. Intra-individual theories blame abuse on some (usually pathological) characteristic of the abuser. Many studies of child abuse have relied on the idea "that the parent who abuses his or her child suffers from some psychological disease which must be cured to prevent future abuse" (Gelles, 1974). Similarly some writers have attributed spouse abuse to sadistic personality traits (Young, 1974; Shainess, 1975; and Faulk, 1974). But Richard Gelles (1974) in his studies of family violence severely criticizes such intra-individual explanations of abuse. He argues that little agreement exists between various writers as to which pathological traits characterize abusers; that the studies do not rigorously test hypotheses, and that they rely on clinical samples without use of non-abuse comparison groups.

However, numerous studies have found support for a relationship between alcohol and drug abuse and family violence. While it is not clear precisely how substance abuse leads to violence, the two behaviors have been reported to occur together so frequently that it cannot be ignored as a contributing factor in abuse. Whether alcohol or drug consumption acts to diminish inhibitions against violence; or to allow for "deviance disavowal," they appear to pave the way for abuse in some circumstance.

Interestingly, the psychopathological theme has also largely been shunned by elder abuse researchers, although one early study does include as one cause of abuse the "flawed development" of the abuser, which resulted from problems in his or her childhood (Douglass et al, 1980). Another does refer to the problem of a non-normal adult child (e.g., mentally ill, alcoholic or retarded) who has been cared for by parents for all of his or her life, but who is not able to cope when these parents themselves need care. (Lau and Kosberg, 1979).

There is a more theoretical argument in favor of at least considering the role of psychopathology in elder abuse. A major difference exists in the degree of normative prohibition against various types of family violence. Straus, et al. (1980) found a great deal of popular approval for physically punishing children, and even a surprisingly high approval rate for spousal violence. However, it can be argued that it is a much more deviant act to strike an impaired, dependent elderly person. There is no normal pattern for being violent towards one's elderly relatives. It is therefore, a stronger normative violation than either child or spouse abuse. Consequently, one might expect a greater degree of psychopathology on the part of elder abusers. They must engage in a more deviant behavior than others. Although researchers in child and spouse abuse are now less prone to attribute family violence to the psychological state of the abuser, it appears that persons who abuse elders may be more severely disturbed than others. Both the results from the 127 individual case reports completed by community agencies and the 328 case assessments from the three Model Projects show that almost one out of three of the perpetrators had a history of mental illness and two out of five were alcohol abusers.

Intergenerational Transmisssion of Violent Behavior. Another explanation for abuse is the "cycle of violence" theory, a hypothesis grounded in social learning theory, which holds that the child learns to be violent in the family setting. When frustrated or angry as an adult, the individual relies on this learned behavior and lashes out violently. Gelles and Straus (1979) in their extensive review of the literature on this subject, report that the frequency with which this "cycle" has been found gives creedence to the assertion that people learn to be violent by experiencing and witnessing violence in their own households while growing. In many cases, they claim, "there appears to be an almost undiluted 'transfer' with violence learned as a child practiced as an adult."

Question regarding whether the perpetrators of elder abuse and neglect had experienced violent upbringings or had been responsible for other acts of violence were included in the community agency survey as well as the case assessment forms used by the Model Projects. Except in a few instances, the community agencies did not have knowledge of prior acts of abuse or violence by the perpetrators in their files, nor was there information available concerning any unusual aspects of their family background, including any abuse in their childhoods. Even after lengthy involvement with Model Project cases, sometimes extending more than one year, the social workers could not obtain information on three-quarters of the abusers. Of the seventy perpetrators for whom there were data, twenty five had not been victimized nor had they engaged in other violent acts; forty-five had engaged in other acts of violence, including child and spouse abuse and assault and battery; and thirty-two of the seventy had been abused as children.

Dependency and Exchange Relationships. The belief that the dependency of elderly individuals is a major cause of abuse is probably the most widely held one in the literature. Dependency is defined as "requiring the assistance from another person or persons to continue to live in the community." This view has developed in large part from recent gerontological research which cite decreased freedom, lack of privacy, irritation, guilt, fear, anxiety, anger, hostility, career interruption, and financial strain among the problems that can result from providing care to impaired elderly relatives. Based on such findings, a number of investigators have assumed that the growing dependency of an elderly person increases the likelihood of abuse. Steinmetz (1982) has been perhaps the major exponent of this view, arguing that families undergo "generational inversion", in which the elderly person becomes dependent on his or her children for financial, emotional, physical, and/or emotional support.

Indeed, the results of all the studies on abuse and neglect of the aged include physical and mental impairment as part of the profile of the elder victim, although there is a variation in the degree that is reported. Seven out of ten victims from the Model Project case load had problems with the instrumental tasks of daily living (e.g., meal time activities, shopping, household management, etc); six out of ten needed help with activities of daily living (e.g., personal care, etc.); and five out of ten had problems with orientation and memory at least some of the time. Generally, the comparison group of fifty non-abuse/neglected cases showed less functional dependence, especially with regards to orientation and memory. About one out of six had cognition problems some of the time.

The hypothetical relationship between dependency and abuse fits quite well into exchange theory which has come to be used rather widely by both family violence researchers and gerontologists. Exchange theory holds that humans attempt in relationships with others to maximize their rewards and minimize their costs. In addition it states that the provision of a reward to someone else obligates that person to the former. When reciprocity is no longer achieved, the relationship end. However, families provide special instances of exchange in which it may not be feasible to end interaction, even when reciprocity is absent. In such a situation, it is argued, abuse can occur. As the costs of the relationship grow to the caregiver, and the rewards diminish, the exchange becomes perceived as unfair. If the caretaker feels unable to escape the situation, he or she could then become abusive. In the light of the fact that abuse occurs in only a small proportion of families, no direct correlation between dependency of an old person and abuse can be assumed, although it is often inferred.

A situation which as yet has not been given much attention in the abuse literature concerns the continued dependency of the abuser on the abused. In two-thirds of the cases reported in the community agency survey and Model Project administrations, the perpetrator was financially dependent on his or her victim. These abusers received financial assistance and usually housing from the victims. Thus, the assumption that the dependency of the elderly person breeds abuse may be too simple. Instead it appears that some abusers and abused are tied to one another by a long and complex relationship of mutual dependency.

The question now arises: Why would the continued dependency of adult child or spouse upon an elderly person cause physical abuse? Finkelhor (1983) in his attempt ot identify common features of family abuse, notes that abuse can occur as a response to perceived powerlessness. Acts of abuse, he notes, "seem to be acts carried out by abusers to compensate for their perceived lack or loss of power." It may be that the feeling of powerlessness experienced by an adult child who is still dependent on an elderly parent is especially acute, because it goes so strongly against society's expectations for normal adult behavior.

External Stress. In the past decade, sociologists in a number of areas have increasingly come to focus on stress. As Straus (1979) has asserted, the nuclear family constantly experiences major changes as a result of the family life cycle: birth of children, aging and deterioration of members, death among others. Further, he notes, that stress interferes with what families are expected to do: provide food, clothing, and shelter, for example, and raise healthy, well-adjusted children. But society does not always bestow upon families the resources to accomplish these things. It is therefore no surprise that investigators have found a positive relationship between external stress and abuse. Gil (1971) was one of the first researchers to cite such stressors as poverty and unemployment to be causes of child abuse. In Gelles and Straus's (1979) terms, it is a "socio-cultural" theory, rather than a social-psychological or intra-individual one, with emphasis on social structural, macro-level variables like unemployment or economic conditions. However, as Sengstock and Liang (1982) have argued, the social stress model alone cannot explain elder abuse as it does not account for why some families respond to stress with abuse and others do not.

Several questions were placed on the Model Project assessment form to test the hypothesis that the burden of caring for an elderly relative along with physical, mental, social or economic stresses on the abuser may lead to abuse and neglect. When asked to rate the degree of stress in the lives of the abusers, the workers at the three Project sites marked "a lot" for over one half of the group. Specific references were made in two out of five cases to "demands for attention", in one out of three, to "incontinence"; and one in four, to "verbal assault". Two out of five of the perpetrators themselves had experienced a recent change in their mental health and family relationships. Still further evidence of strain in the lives of one quarter of the abuser group was attributed to financial difficulties and medical complaints. A comparison of the sub-set of abuse/neglect cases with the non-abuse/neglect cases indicated that there was a significant difference in the degree of stress on the abusers compared to the caretakers of the non-abuse clients, particularly regarding the change in family relationships and living arrangements.

Social Isolation. It is important to consider the degree of social isolation of a family as a cause of abuse; firstly, because ther is a vast body of literature which supports the thesis that social support acts as a moderator of life stress and facilitates coping with crises (Cobb, 1976; Wan, 1982) and secondly, because at least one gerontological research group (Zarit, 1980) has found that active support from kin reduces feelings of burden on the part of caregivers to the elderly. The analysis of the Model Project data indicates that the elder abuse families do have little socialization. About one out of five had no contact with anyone other than the abuser or formal caregivers coming into the home. Another one out of five had only one other person with whom they were in contact. Only one in ten had five or more persons whom they saw on a regular basis. Compared to the non-abused/neglected group the victimized elderly had fewer and less frequent contacts.

There is evidence in the gerontological literature and now from the evaluation study of the Model Projects on Elderly Abuse to support each of the theoretical explanations that have been proposed. Except for the "cycle of violence" theory for which data have not been forthcoming, intra-individual dynamics, dependency, stress and social isolation have been identified as playing a role in abuse/neglect situations involving the elderly. Further analysis of the Model Project data is underway to determine if specific theoretical explanations are more closely associated with particular types of abuse (e.g., physical, psychological and material abuse, and neglect (e.g. active, passive).

Intervention Models

While there is now a substantial body of knowledge concerning the nature of elder abuse and a fairly consistent profile of the elder abuse victim and perpetrator, there is much less information about the intervention models and their effectiveness. No matter which sector of the human service system takes primary responsibility for case assessment and management, there is general agreement that the approach should be multidisciplinary and facilitate service coordination.

The three demonstrations represent three varients of a social service model: one is designated a "service brokerage" model since it is located in an agency where the workers have direct control over a wide range of social services. Their function is to identify and assess the victim and abuse situation, manage the services which are required, and provide counselling to both the abused and abuser if necessary. A committee composed of a physician, lawyer, retired judge, police officer, social worker, mental health practitioner, retired persons, and home health nurse advise on individual cases as well as on policy. Case conferences with family members and other professionals are called when needed.

The second model is fashioned after a sucessful child abuse project. For each case, a team, made up of service providers and others involved in the situation, is formed, and is convened again when needed. This program also employs a group of specially trained aides who work with the most troublesome cases. The third model operates out of an agency which is designated by law to receive and investigate reports of abuse and neglect under mandatory reporting legislation. The staff also fills a coordinating role and provides counseling, but these activities take place within the context of mandatory reporting. Their objective is to turn the cases over as soon as possible to appropriate local groups. Each of the Model Projects works most closely with a home health agency, a mental health counseling service, a senior service program, such as a senior center, the local Adult Protective Service Unit, and, in the case of the agency which functions under mandatory reporting legislation, with the police. Legal, medical, and housing agencies represent a second level of resources which were called upon to assist in abuse and neglect cases.

Unlike child abuse which received its impetus from the medical profession, elder abuse has been mostly a concern theoretically to sociologists and practically to the social service system. Only more recently have health care professionals begun to take an active role. O'Malley et al, (1983) reported in their article last year in the Annals of Internal Medicine that from 1978, when the problem first appeared publicly, to 1983 no substantive article and only two editorials on domestic elder abuse appeared in any of the major American medical journals. Consequently, he adds, few primary care physicians are aware of the studies which have been published about the problem. A recent survey of the New York State Offices for Aging and Department of Social Services (Wolf, 1983) showed that a large majority of them received no referrals from physicians, or lawyers and clergy either for that matter, groups that are apt to know aboutsituations involving abuse, but who are reluctant to report to public agencies. Yet, many of the victims need and are entitled to the services which they offer.

One of the first medical models for intervention in cases of elder abuse and neglect is based in the long term care gerontology center attached to the University of Washington teaching hospital (Hooyman and Tomita, 1981). It includes a nurse, mental health counselor, social worker and physician who follow patients into the community and work with the families. Another model organized to respond to situations in the emergency room includes a physician, house officer on duty, nurse, social worker and ethicist, the latter present to assist in decision making particularly when there is a question regarding the competency of the victim or perpetrator. A specially designed protocol has been developed and is used with all elderly patients admitted to the emergency room. O'Malley et al.(1983) suggest as an ideal model one that has a team of caregivers from the medical, social service, mental health and legal professions tightly integrated into a primary health service network so that home based nursing and physician care, hospitalization and mental health services can be coordinated. One of the group is designated as the case manager and provides the continuity. Members of the nursing and allied health professions have also been examining their role in the identification, assessment and treatment of abused/neglected elders.

Dilemmas For Practitioners

The nature of elder abuse and the characteristics of the intervention strategies raise a number of potential conflicts for practitioners. While tangible proof may be obtainable in situations involving physical and material abuse, evidence of psychological abuse and neglect is far more difficult to come by. Cultural biases and lack of full knowledge about the circumstances involved may lead the worker to false conclusions. The instability of the mental and physical status of the victim and/or the perpetrator and the complexity of their relationship may add to case uncertainty. The individual who appears to be the victim on first investigation may be the perpetrator. The worker may be required to report the circumstances before the question of innocence or guilt can be firmly established. Whether the problem is a social or criminal one may be unclear. Some acts are prosecutable; but some may not be. Certainly, the unwillingness of the victim to press charges has been found to be a hindrance to intervention efforts. Even though the law may require an investigation, the older person may not wish to cooperate or to accept the services that are offered. Lack of receptivity to help by the perpetrator and the elder victim are the major barriers to effective case resolution in all elder abuse and neglect studies. This negative response brings the worker face to face with a major dilemma.. the interest of the state and the professionals in protecting vulnerable persons on one hand and the individual's right of self-determination and privacy on the other. Many times workers are left with feelings of powerlessness and inadequacy.

The issue of competency can be particularly troublesome. There may be resistance on the part of the victim to undergo medical assessment, or the perpetrator to allow it, or even the medical profession to make a decision. The organizational structure for case intervention poses another set of problems. If a multidisciplinary team is established, it is subject to some of the conflicts concerning roles, status, and vocabularly associated with team efforts. Assignment of responsibility for management of a case may be a serious impediment to the optimal functioning of a service coordination model.

For the aging network there is still another dilemma. Domestic abuse and neglect is primarily a family problem which requires that workers must be involved with family members, sometimes three generations. Age limitations such as those found in the Older Americans Act or other statutes become barriers to effective service delivery and challenge the wisdom of some of our current age-segregated policies.

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EXHIBIT 8

THE RELATIONSHIP BETWEEN ORGANIZATIONAL STRUCTURE AND CLIENT OUTCOME IN THREE MODEL PROJECTS ON ELDERLY ABUSE

Rosalie S. Wolf
Karl A. Pillemer
University Center on Aging
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, Massachusetts 01605

Paper prepared for presentation at the Second National Conference For Family Violence Researchers, August 9, 1984, University of New Hampshire, Durham, New Hampshire.

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THE RELATIONSHIP BETWEEN ORGANIZATIONAL STRUCTURE AND CLIENT OUTCOME IN THREE MODEL PROJECTS N ELDERLY ABUSE.

Background

Six years ago Suzanne Steinmetz, testifying on family violence before a House Sub-Committee, startled the audience and the nation with a report on "battered parents" (Steinmetz, 1978). Although the initial reaction was one of disbelief and righteous indignation, studies conducted in the subsequent two years showed that elder abuse was occurring nationwide and that its incidence was rising. These early research reports produced profiles of the victims, perpetrators, and abuse/neglect situations but little information about the intervention strategies and results.

Because of the sense of urgency associated with the problem, the Administration on Aging designated elder abuse as one of the priority demonstration areas for funding under its 1980 Model Projects program. Three organizations received three-year grants to demonstrate improved mechanisms for reporting, investigation, treatment, and prevention of elder abuse and neglect. They included the Massachusetts Department of Elder Affairs, which contracted with one of its affiliated home care corporations, Elder Home Care Services of Worcester Area, Inc., to conduct the demonstration; the Metropolitan Commission on Aging of Onondaga County which contracted with Alliance Division of Catholic Charities of Syracuse and the Rhode Island Department of Elderly Affairs which chose to operate the Model Project from the state office. A grant for evaluating all three Projects was given to the University Center on Aging at the University of Massachusetts Medical Center. The adoption of a common set of definitions of abuse and neglect and assessment instruments by the three Projects made it possible not only to compare the case loads but also the organizational structure, intervention process and outcomes.

It is important at this time to emphasize the fact that the primary purpose of the evaluation of the Model Projects as outlined in the funding application was for program planning and development. A methodology was selected which would be least disruptive to the Model Projects, which would incorporate forms already part of the day-to-day operation for the agencies, and which would involve project personnel in decision making. For all project staff, the tasks required for the evaluation (completing case assesments and reassessment forms, time studies, organizational analyses) were added to their responsibilities as case workers or project directors. Although there were opportunities at joint staff meetings to discuss the assessment forms, the client data from the sites (other than the sociodemographic statistics) reflect the training, experience, and judgment of the respective project workers, rather than the findings of an objective researcher. The plan of this paper is to summarize briefly in the literature on intervention strategies and organization related to elder abuse and neglect, to describe the models and the organizational performance and to analyze the outcome of the three Projects.

Selected Literature Review

Despite the attention which elder abuse and neglect have received in the past five years, particularly from the media, there have been only a handful of studies on the topic, and they have been primarily concerned with defining the problem and its causes. Interest in intervention strategies has focused mainly on clinical aspects with little information in the literature on organizational issues. Lau and Kosberg (1979) in their retrospective study of victims seen by a chronic illness facility outline the steps required to handle a case (establish a positive relationships, engage other relatives or homemakers, provide regular nursing care) but do not suggest a model for delivering these services. In their discussion of intervention strategies based on a survey of professionals, Block and Sinnott (1979) note that action may involve social services, civil sanction and criminal proceedings, but found that none of the 26 victims of elder abuse reported in their survey had received any assistance at all with the abuse problem. The Massachusetts Survey of professionals and paraprofessionals by the staff of the Legal Research and Services for the Elderly (O'Malley, Segars, Perez, Mitchella and Knuepal, 1979) was the first to document the type of intervention action that had been taken in behalf of the victims: direct services were provided in 62 percent of the cases; emergency provisions in 22 percent; and referral in 48 percent. Data from 183 cases included a wide variety of interventions, most often consisting of social service, counselling, arrangements of in-home services and removal of the victim. The researchers raise the question as to whether these responses were appropriate, or a function of the availability of services in the area, professional style or bias.

After surveying direct service providers in Michigan regarding their experience with elder abuse and neglect cases, Douglass, Hickey and Noel (1980) conclude that the different types of abuse reported by different professional groups may be due to particular settings, training, and perspectives. From the results of their survey of the Detroit area, Sengstock and Liang (1982) suggest that effectiveness of services seem to be highly dependent on the characteristics of the agency and the worker. In a sub-sample of that study drawn from the case files of a legal agency which had shown considerable success in working with such problems, Sengstock and Barrett (1982) found that legal agencies may be more likely to act directly in behalf of clients while social service agencies are more inclined to counsel the family or to refer to another agency. These researchers add that legal agencies rarely deal with the family problems which may have generated or contributed to the episodes of maltreatment.

More recent reports in the literature have given somewhat greater attention to the intervention process. Pratt, Kane and Lloyd (1983) in their study of service workers' response to abuse of the elderly state that it is unlikely that any one individual in aging can adequately assist families in alleviating the factors contributing to elder abuse. Such situations require the coordinated effort of a number of professionals and service agencies. Writing on "clinical interventions with abused elders and their families," Humphreys, Campbell, and Barrett (1983) also note that the complex phenomenon of family violence requires the involvement of numerous professionals and a coordinated approach to attain the maximum results from the intervention. The emphasis on coordination is also made in two guides issued for practitioners. Villmoare and Bergman (1981) characterize an effective service system as one which has the "capacity for a coordinated, interdisciplinary response" to both chronic and emergency situations. The National Guide Series on Improving Protective Services outline a number of coordination methods (Hornby, 1982). While the literature on elderly abuse and neglect has not dealt directly with program models and effectiveness, it has made the point that whether handled by social, legal or health agencies, a coordinated approach is necessary.

Methodology

As noted earlier, the evaluative research of the three Model Projects offered an opportunity to move beyond the clinical investigations and to study the organizational models, their performance and outcomes. Several different data collection techniques were employed. Indepth interviews were held with the Model Project staff, other personnel in the same agency and selected individuals in community organizations. The status of the abused elders the abusers, and abuse situation and the barriers to service delivery were assessed by the Project staff on 328 cases at intake and on 310 at reassessment, approximately 7 months later. A third set of data was obtained from community agencies, first surveyed at the beginning of the grant period and then two years later, approximately 210 agencies were surveyed each time. Chi-square analysis was used to test for significant differences among the sites.

Results

After a short description of the three Model Projects, three aspects of organization performance will be presented: implementation, coordination and time analysis. Case resolution, barrier to service delivery and community agency response have been selected as measures of project outcome.

Characterization of the Model Projects. Although the Projects did show some variation with respect to specific characteristics, the goals, target population, staffing and definitions of abuse and neglect were alike. All three had the primary purpose of providing casework services to abused and neglected elderly (60 years and over) and members of their families. The goal was to intervene in cases of maltreatment, to introduce services when appropriate, to counsel victims and relatives, and to help resolve conflicts between abuser and abused. In addition to this objective, the Model Projects were to function as coordinators among other service providers and to serve as a focal point for action by local agencies in behalf of abused clients. Finally, all three Projects had the responsibility of educating the community concerning the problems of abuse and neglect.

Another point of similarity was the target population. Only domestic abuse and neglect cases were included; professional, institutional, and self abuse were excluded. With regards to staff support and budget, the projects operated at about the same level. Each employed a director (full or half-time) and a full time case worker, although the Rhode Island project did hire an Information and Referral Specialist as a result of the mandatory reporting legislation.

In spite of these similarities, each Project represents a specific service approach to elder abuse and neglect.

Since the Worcester Project is located in an agency where the case workers have direct control over a wide range of social services that can be used to help with a case (i.e., homemaker, transportation, chore, friendly visiting, senior companion, etc.) In addition to identification and assessment of the victim and the abuse situation, a major function of this Model Project is to manage and monitor the services which are provided. Two basic components stand out in the Syracuse Project which are more aptly described as a "coordination model". Interagency coordination is highlighted by the convening of a formal service team for most cases and specially trained aides work with the most troublesome cases. As the only official unit among the three Projects legislated to repond to abuse reports, the Rhode Island project emerges as a distinct type, a "mandatory reporting" model. It has primarily a short term focus and relies on other agencies to provide direct services and to monitor the case. The role of the Rhode Island Project is to act as a catalyst for action, to bring together the relevant resources, and to remain in the picture until the abuse situation is alleviated.

Implementation. Generally, the implementation of the three Model Projects proceeded relatively smoothly. While the presence of "abuse" workers was seen as an asset in all three sponsoring agencies, defining the workers' roles vis-a-vis those of other workers in the Worcester agency did present a problem. Although having the Model Project within the agency relieved case managers of difficult cases, some social workers found abuse and neglect cases interesting and satisfying and were less than willing to relinquish them. This situation was at least partially resolved by arranging for the "co-management" of the case. In such instances, the case manager remained involved, but received advice and direction from the Model Project staff member.

At the Syracuse Project, no such "turf problems" existed with other workers, since within the home agency (Alliance), there was no other staff members working directly with elders. In Rhode Island, however, it occurred on a small scale in the intake process. The Elder Abuse grant allowed for the hiring of one intake worker for the Information and Referral Unit. When it proved to be extremely difficult to transfer abuse reports to the one person, a decision was made to share elder abuse intake duties among the entire I&R staff, all of whom were trained to carry out this responsibility.

With regards to interagency implementation, two problems became evident. The first one, shared by all the Projects, was that of obtaining clients. By visiting relevant agencies in their areas, arranging for media announcements, and conducting training sessions, the Model Projects were able to make themselves known and to generate referrals. After these initial attempts, cases came very quickly. In fact, the Model Project workers found other agencies only too willing to transfer complicated and frustrating abuse cases to them.

A different problem occurred in the Syracuse and Rhode Island sites. At both locations, an Adult Protective Services (APS) unit existed in another agency, that legally had overlapping responsibilities with the Model Project. Both were forced to answer the question: What is special about what you offer? These two Projects were able to reach an agreement with the APS units, arguing convincingly that they were free of the stigma associated with the welfare agencies in which both APS programs were located. By maintaining open lines of communication with these APS programs and, in particular showing a willingness to take over the more troublesome clients, the Model Projects avoided serious conflict.

Coordination. While the precise extent of elder abuse/neglect is now known, it is clear from the research that such cases are often very complicated and difficult. They generally require the involvement of a number of social service, health and legal agencies before they are resolved. A critical question for the analysis of the Model Projects was: How does interagency coordination take place?

Each project was asked to list the agencies with whom they worked most closely. The answers were similar for all three sites. They included a home health agency, a mental health counseling service, and a senior center. Rhode Island and Syracuse added the APS unit in their welfare departments with whom coordination was essential. Rhode Island, unlike the other Projects, also listed the Police Department. Due to their increased legal responsibilities under mandatory reporting, the Rhode Island Model had much closer ties to the police than the other two Projects. All three had extensive contact with community agencies, making use of both informal and formal mechanisms to maintain agency linkages.

A major problem in interagency coordination is assigning responsibility for management of the case. Most often among the Model Projects, the decision was based on the client's primary problem. If it was health related, then the home health agency was likely to take charge, and the Model Project was called in for consultation. If the case presented itself initially as an abuse case, the Model Project tended to manage it, and consulted with other agencies as needed. Interagency coordination was found to be more important to the Rhode Island and Syracuse Model Projects than to Worcester. Since the latter controlled many services within its own organization, it required less contact with other agencies, but, conversely, it experienced more intra-agency coordination problems.

Syracuse and Rhode Island established special programs to facilitate agency coordination. For every client, the Syracuse staff organized a "team" which at a minimum involved a Public Health Nurse and the APS worker. This team met formally as needed to review the case and followed its progress at other times through telephone contact. Rhode Island made use of "key councils," groups of elder service providers in local communities that met on regular intervals to discuss common cases. A special sub-committee of the Providence Key Council was established to work with the Model Project.

Of the three abuse programs, the Rhode Island group experienced the greatest difficulty in interagency coordination, which appeared to be attributable to the constraints demanded by mandatory reporting. Because this Project received a very large number of referrals, many more than could be handled by the Project staff, an attempt was made to transfer control of the cases to other agencies as quickly as possible. Also, Worcester and Syracuse had concrete services to offer, i.e., home care services and geriatric case aides, while the Rhode Island Project was forced to ask other agencies for help, for which, because of the time constraints, they had less to give in return.

Time Analysis: In order to obtain a more complete picture of the staffing pattern, Model Project personnel were asked to complete daily time sheets for one month, February 1983. Activities were divided into two general types: client-related, which included screening, referral, interviews, case conferences and the like; and non-client related, which encompassed such activities as Project administration, staff meetings, providing and receiving training, and others. These time sheets were tallied, and a composite picture for each month was developed. The breakdown of time between social workers and directors is broadly similar, in that social workers devoted considerably more time to client-related services than did the project directors. As would be expected, the Project directors devoted more time to agency relations, staff meetings, and Project administration.

One particularly interesting difference emerged between the three Projects. The social worker in Worcester spent a considerably greater percentage of her time in client interviews/homevisits (29.6 percent) than did the workers in the other two projects (5.8 percent, Syracuse, 5.4 percent, Rhode Island), probably due to the case management model, which requires periodic in-person assessment and monitoring. The Worcester social worker spent less time than her colleagues in the other two projects in case recording/correspondence, in part because the Worcester agency served fewer total clients during the course of the demonstration. Evidence from the time analysis supports the notion that the approach of the Worcester Project involved more intensive and extensive involvement with fewer cases than that of the Syracuse or Rhode Island models.

Case Comparisons. Before discussing the relationship of outcome to organizational structure, it is important to compare the case loads. Three groups of variables were selected for this purpose: sociodemographic for both the victim and perpetator; those related to the "causes" of maltreatment (stress, social isolation, dependency, psychopathology of the perpetrator) and type of abuse. To eliminate as much respondent bias as possible in these inter-project comparisons, variables which relied on the subjective interpretation of the social workers were eliminated.

As Table 1-2 indicate, there were no differences among the three groups of victims regarding their age, sex, martial status, and living arrangement, and among the perpetrators, their sex and living arrangements. Only the age of the latter varied, with the Rhode Island case load having a significantly larger percentage (51.3) of abusers under 50 years of age than Worcester (39.0) or Syracuse (35.7).

There was no difference among the site case loads in the victim's use of supportive devices and weight change (variables used as proxies for health status) although the Syracuse case workers found their victims to be more a source of stress ("a lot" and "a little", 88.6 percent) than Worcester (80.6 percent) and Rhode Island (76.2 percent) (Table 3). In terms of socialization, (frequency of contacts and attendance at church/clubs) the groups were not alike. Rhode Island reported less frequency of contact for its clients; 33.6 percent of group had contact with others outside the household monthly or less compared to 19.2 percent of the Worcester and 16.5 percent of the Syracuse abused elders. Attendance at church or club meetings also varied significantly among the sites. Again, Rhode Island reported that 96.1 percent of their clients did not attend these activities while Worcester showed 86.2 percent and Syracuse, 93.1 percent. Finally, a comparison of the case loads on the basis of the perpetrator's psychological state (history of mental illness and alcohol abuse) showed no significant difference among the three Projects (Table 2).

On the whole, the case loads of the three sites were remarkably similar. The abused clients differed in the amount of socialization and the perpetrators in age. The most critical difference, however, among the sites was the variation in proportion of physical abuse and passive neglect. Just about half (49.3 percent) of the Rhode Island cases listed physical abuse as the type which precipitated the report to the agency in contrast to about one-third (35.6 percent) of the Worcester case load and a little more than one-fourth (28.9 percent) of the Syracuse. On the other hand, almost one out of five (18.6 percent) Worcester and Syracuse cases checked "passive neglect" as the precipitant of the report compared to about one in fifteen (6.7 percent) for Rhode Island (Table 4).

Case Resolution. For the purposes of the evaluation, case resolution was defined as the reduction or elimination of the circumstances which had resulted in the abuse or neglect. According to Table 5, there was a significant difference in the degree to which the cases were resolved with the Worcester Project reporting the largest proportion of cases "not resolved" or "a little", 35.2 percent, Syracuse, 22.9 percent, and Rhode Island, 26.4 percent. In all sites, however, at least one-third of the cases were reported as resolved with Rhode Island showing the highest percentage, 41.5. A fairly large proportion of these cases involved the separation of the abused and abuser. A closer look at case disposition reveals that 28.8 percent of the Worcester victims were at the time of the case re-assessment in new living arrangements, 35.4 percent for Syracuse and 26.4 percent for Rhode Island (Table 6).

Barriers to Service Delivery. To provide further information concerning case resolution, the staff were given a list of possible barriers to service delivery and asked to note the degree to which they had hindered the particular case effort: "not at all", "a little", or "a lot". When the three Projects were compared on the nine barriers (see Table 7) the differences were significant for only four of them. The first, "number of agencies", was cited by Worcester as a barrier which hindered services "a lot" in two cases (5.6 percent) and by Syracuse "a little" in two cases (2.6 percent), but not at all 'y Rhode Island. The "receptivity of the abused to help" was recorded as hindering case efforts "a lot" in about one-quarter of the Worcester cases (26.9 percent) and Rhode Island (22.8 percent) but in less than one-tenth of the Syracuse cases (9.5 percent). Likewise the "receptivity of the abuser" was found to be a barrier which hindered treatment "a lot" in about two out of five Worcester cases (41.7 percent) and Rhode Island (44.7 percent) but less than one out of five of the Syracuse group (15.7 percent). The Worcester staff reported "availability of services" to be a barrier which hindered service delivery "a lot" in 21.2 percent of the cases while Syracuse noted a similar finding for only 6.5 percent of their cases and Rhode Island for 4.3 percent. The final significant barrier was "lack of protective services" which Rhode Island reported as hindering their efforts "a lot", 42.1 percent of their cases compared to 16.7 percent for Worcester and 1.5 percent for Syracuse.

Community Agency Responses. Another source of information concerning the outcome of the Projects was obtained from the survey of community agencies. One hundred and one agencies in the Worcester area returned the survey form, fifty-two in Syracuse (Onondaga County) and sixty in Rhode Island (Table 8). When asked, "Are you aware that there is a specific project in your area dealing with abuse?", more than three-quarters of the agencies replied affirmatively, with the highest percentage (86.5) registered by the Syracuse area. Those agencies responding "yes" were then asked whether they had referred a client to the Project. About forty-five percent of the Syracuse agencies said, "yes;" about half of the Worcester group; and two-thirds of the Rhode Island group. The agencies then were asked to rate the response they had received from the Model Project. At least six out of seven agencies in all sites marked "excellent" or "good."

Of the thirty-nine agencies in the Worcester area answering this question, thirty-six were very positive. The most common adjective they used was "prompt." Several commented that the service was "excellent," and a few others singled out its "comprehensiveness." The agencies listed a variety of tasks which were performed by the Model Project, noting especially "follow-up." Among the Rhode Island agencies that completed the questionnaire, thirty-four added comments about the response they had received from the Project. Of these, thirty were favorable; seven cited the timeliness of the response and five wrote "good" to describe the agency's efforts. Twenty-two of the fifty-two agencies returning questionnaires in the Syracuse area added comments about the response from their Elder Abuse Project. All were positive except for two; four agencies remarked about the "promptness of the response," and several agencies described the Model Project efforts as "very good." Some agencies also singled out "follow-up" as a particularly commendable aspect of the Project's response.

Because of the importance of "coordination" in providing services to abused and neglected elders, the agencies were asked "if involved in cases of abuse, indicate the degree of satisfaction with the extent of cooperation or coordination of services in your area." Again, the most positive response came from the agencies in the Worcester site, over two-thirds of whom (68.9 percent) marked "very satisfied," and a little over one-quarter (28.9 percent) as "reasonably satisfied." The Syracuse area agencies were almost equally divided with 46.2 percent saying that they were "very satisfied" and 53.8 percent as "reasonably satisfied." Among the Rhode Island agencies, there were about one-third (35.3 percent) who were "very satisfied" and almost two-thirds 61.8 percent, "reasonably satisfied." Only one agency responded "not at all satisfied" in the Worcester and Rhode Island surveys.

Discussion

A variety of data has been presented here that involves client characteristics, case resolution, barriers to intervention, and perceptions of other agencies. Among the sites, there were only a few differences found in client characteristics, the most important being the type of abuse/neglect which precipitated the report. Rhode Island had the highest proportion of physical abuse and lowest proportion of passive neglect cases, and Syracuse, vice versa while Worcester had the same proportion of passive neglect as Syracuse but more physical abuse. Regarding client outcome, each Project reported a majority of cases as being resolved at least "a little", "a lot" or "completely". However, the Worcester group included one-third of its cases in the "not resolved" or resolved "a little" categories compared to about one-quarter for Syracuse and Rhode Island.

Since there seemed to be no systematic relationship between abuse/neglect type and client outcome, the analysis then focused on the impact of the organizational models. Although they were similar in many respects, two differences stood out: the strategies adopted to promote coordination and the extent/degree of staff involvement in direct client services. With respect to coordination effects, there was no difference among the sites in the degree to which "coordination of services" and "coordination of agencies"hindered case management. If, indeed, coordination of services is a key factor in achieving case resolution, then the Worcester Project should have had the best record since the agencies in Worcester were more satisfied with the coordination of services than those in Syracuse or Rhode Island.

The one important factor which does emerge as a possible explanation for the difference in case resolution among the sites is the extent/degree of involvement in direct client services. The Worcester staff saw a much smaller number of clients over a long period. Their style of practice involved lengthy case work with families while Rhode Island used a short term intervention and referral strategy and Syracuse took a sort of middle road with greater likelihood of relocating clients to new living situations. Rather than leading to a higher degree of case resolution, the Worcester approach apparently made the staff more aware of the family dynamics. Because of their deep involvement in these family situations, the Worcester staff seemed to be less willing to label them "resolved." This interpretation may also may explain why they found "receptivity of the abused and abuser" to be more of a barrier than either Rhode Island or Syracuse. This explanation will of course require further exploration. If the Worcester project was truly unable to resolve cases in spite of devoting such extensive resources to them, then the desirability of replicating that model may be called into question.

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TABLE 1 A COMPARISON OF THE VICTIMS OF ELDER ABUSE/NEGLECT BY SITE - SOCIODEMOGRAPHIC FACTORS

	Worcester	Syracuse	Rhode Island
	# %	# %	# %
Age	n.s.		
59-64 years	11(18.6)	15(11.2)	27(20.3)
65-74 years	13(22.0)	35(26.1)	40(30.1)
75-84 years	25(42.4)	47(35.1)	46(34.6)
85 years and older	10(16.9)	37(27.6)	20(15.0)
No Answer	-	1	1
Sex	n.s.		
Male	12(20.3)	21(15.6)	27(20.1)
Female	47(79.7)	114(84.4)	107(79.9)
Marital Status	n.s.		
Single	7(12.1)	8(6.0)	10(8.0)
Married	21(36.2)	41(30.8)	38(30.4
Widowed	26(44.8)	72(54.1)	61(48.8)
Divorced/Separated	4(6.9)	12(9.0)	16(12.8)
No Answer	1	2	9
Living Arrangements	n.s.		
Lives alone	9(13.6)	37(27.6)	31(23.3)
Lives with others	51(86.4)	97(72.4)	106(76.7)
No Answer	-	1	1

n.s. = no significant difference in chi-square analysis

TABLE 2 A COMPARISON OF THE PERPETRATORS OF ELDER ABUSE/NEGLECT BY SITE

	Worcester	Syracuse	Rhode Island
	# %	# %	# %
Age	p=.0386		
Under 50 years	23(39.0)	46(35.7)	61(51.3)
50 years and over	36(61.0)	83(64.3)	58(48.7)
No answer	-	6	15
Sex	n.s.		
Male	42(71.2)	78(58.6)	84(66.1)
Female	17(28.8)	55(41.4)	43(33.9)
No answer	-	2	7
Perpetrator lives with victim	n.s.		
Yes	49(83.1)	91(67.9)	100(76.9)
No	10(16.9)	43(32.1)	30(23.1)
No answer	-	1	4
History of mental illness	n.s.		
Yes	24(40.7)	48(38.7)	43(36.4)
No	35(59.3)	76(61.3)	75(63.6)
No Answer	-	11	16
History of alcohol abuse	n.s.		
Yes	21(35.6)	49(39.5)	52(44.1)
No	38(64.4)	75(60.5)	66(55.9)
No answer	-	11	16

n.s. = no significant difference in chi-square analysis

TABLE 3 A COMPARISON OF THE VICTIMS OF ELDER ABUSE/NEGLECT BY SITE

	Worcester	Syracuse	Rhode Island
	# %	# %	# %
Victim is source of stress to perpetrator and/or family	p=.0319		
A lot	24(66.7)	74(56.5)	49(55.7)
A little	5(13.9)	42(32.1)	18(20.5)
Not at all	7(19.4)	15(11.5)	21(23.9)
No answer	23	4	46
Victim requires supportive devices/bedridden	n.s.		
Yes	27(51.9)	78(59.5)	46(46.5)
No	25(48.1)	53(40.5)	53(53.5)
No answer	7	4	36
Victim has had recent weight change	n.s.		
Yes	5(14.7)	4(7.0)	3(8.3)
No	29(85.3)	53(93.0)	33(91.7)
No answer	25	78	98
Number of social contacts other than household members	p=.005		
None	11(18.6)	21(15.0)	36(28.3)
1-4	44(74.6)	88(66.2)	83(75.4)
5 or more	4(6.8)	24(18.8)	8(6.3)
No answer		2	9
Frequency of social contacts	p=.0159		
Daily	31(59.6)	85(63.9)	61(55.5)
Weekly	11(21.2)	26(19.5)	12(10.9)
Monthly or less frequently	10(19.2)	22(16.5)	37(33.6)
No answer	7	2	24
Attendance at clubs/church	p=.0490		
Yes	8(13.8)	8(6.9)	5(3.9)
No	50(86.2)	108(93.1)	123(96.1)
No answer	1	19	6

n.s. = no signifcant difference in chi-square analysis

TABLE 4 A COMPARISON OF THE TYPE OF ABUSE/NEGLECT WHICH PRECIPITATED THE REPORT TO THE MODEL PROJECT BY SITE

	Worcester	Syracuse	Rhode Island
	# %	# %	# %
Physical Abuse	p=.0024		
Yes	21(35.6)	39(28.9)	66(49.3)
No	38(64.4)	96(71.1)	68(50.7)
Psychological Abuse	n.s.		
Yes	11(18.6)	36(26.7)	32(23.9)
No	48(81.4)	99(73.3)	102(76.1)
Material Abuse	n.s.		
Yes	13(22.0)	18(13.3)	19(14.2)
No	46(78.0)	117(86.7)	115(85.8)
Active Neglect	n.s.		
Yes	3(5.1)	17(12.6)	8(6.0)
No	56(94.9)	118(87.4)	126(94.0)
Passive Neglect	p=.0092		
Yes	11(18.6)	25(18.5)	9(6.7)
No	48(81.4)	110(81.5)	125(93.3)

n.s.= no significant difference in chi-square analysis

TABLE 5 EXTENT TO WHICH CASES OF ELDER ABUSE/NEGLECT WERE RESOLVED BY SITE*

	Worcester	Syracuse	Rhode Island
	# %	# %	# %
Not at all	7(13.7)	5(4.6)	18(17.0)
A little	11(21.6)	20(18.3)	10(9.4)
A lot	14(27.5)	49(45.0)	34(32.1)
Completely	19(37.3)	35(32.1)	44(41.5)
No Answer	8	26	28

*p= .0089

TABLE 6 STATUS OF VICTIM AND PERPETRATOR AT CASE RE-ASSESSMENT BY SITE*

	Worcester	Syracuse	Rhode Island
	# %	# %	# %
Victim died		15(11.9)	8(6.5)
Victim in nursing home/rest home	7(12.3)	29(23.0)	16(13.0)
Victim in hospital	5(8.8)	7(5.6)	4(3.3)
Victim in new housing arrangement	5(8.8)	9(7.1)	13(10.6)
Perpetrator died/absent	6(10.5)	11(8.7)	17(13.8)
Perpetrator in nursing home	1(1.8)	1(0.8)	3(2.4)
Housing arrangement unchanged	33(57.9)	72(56.7)	62(50.4)
No answer	-	-	2

*total is greater than 100 percent because of multiple responses

TABLE 7 DEGREE OF HINDRANCE OF BARRIERS TO DELIVERY OF SERVICES*

	Worcester	Syracuse	Rhode Island
	# %	# %	# %
Availability of services	p=.0052		
Not hindered	22(66.7)	64(68.8)	59(94.3)
Hindered a little	4(12.1)	23(24.7)	8(11.4)
Hindered a lot	7(21.2)	6(6.5)	3(4.3)
No Answer	26	34	55
Bureaucratic red-tape	n.s.		
Not hindered	20(80.0)	28(73.7)	14(87.5)
Hindered a little	2(8.0)	6(15.8)	2(12.5)
Hindered a lot	3(12.0)	4(10.5)	-
No Answer	32	91	115
Coordination of agencies	n.s.		
Not hindered	37(94.9)	74(90.2)	75(97.4)
Hindered a little	1(2.6)	8(9.8)	2(2.6)
Hindered a lot	1(2.6)		-
No Answer	20	45	48
Coordination of services	n.s.		
Not hindered	32(86.5)	75(91.5)	76(97.4)
Hindered a little	3(8.1)	6(7.3)	2(2.6)
Hindered a lot	2(5.4)	1(1.2)	-
No Answer	20	45	47
Lack of Protective Services	p=.0413		
Not hindered	15(83.3)	62(95.4)	20(52.6)
Hindered a little	-	2(3.1)	2(5.3)
Hindered a lot	3(16.7)	1(1.5)	16(42.1)
No Answer	39	62	87
Lack of respite care	n.s.		
Not hindered	12(70.6)	57(87.7)	50(71.0)
Hindered a little	3(17.6)	4(6.2)	6(19.4)
Hindered a lot	2(11.8)	4(6.2)	3(9.7)
No Answer	40	60	94

*Because some items not appropriate, data not available on entire case loads.

TABLE 7 DEGREE OF HINDRANCE OF BARRIERS TO DELIVERY OF SERVICES (cont.)

	Worcester	Syracuse	Rhode Island
	# %	# %	# %
Lack of support groups-caretakers	n.s.		
Not hindered	11(68.8)	46(69.7)	25(78.1)
Hindered a little	4(25.0)	18(27.3)	5(15.6)
Hindered a lot	1(6.3)	2(3.0)	2(6.3)
No answer	41	61	93
Legal implications of intervention	n.s.		
Not hindered	17(63.0)	60(75.0)	34(75.6)
Hindered a little	6(22.2)	12(15.0)	6(13.3)
Hindered a lot	4(14.8)	8(10.0)	5(11.1)
No answer	50	47	60
Non-reimbursement for services	n.s		
Not hindered	18(85.7)	56(66.7)	17(100)
Hindered a little	1(4.8)	10(11.9)	-
Hindered a lot	2(9.5)	18(21.4)	-
No answer	36	43	108
Number of agencies involved	p=.0197		
Not hindered	33(94.3)	75(97.4)	76(100)
Hindered a little	-	2(2.6)	-
Hindered a lot	2(5.7)	-	-
No answer	22	60	59
Receptivity of abused to help	p=.0120		
Not hindered	24(46.2)	74(70.5)	56(60.9)
Hindered a little	14(26.9)	21(20.0)	15(16.3)
Hindered a lot	14(26.9)	19(9.5)	21(22.8)
No answer	5	22	33
Receptivity of abuser to help	p=.0000		
Not hindered	17(35.4)	65(63.7)	45(47.9)
Hindered a little	11(27.9)	21(20.6)	7(7.4)
Hindered a lot	20(41.7)	16(15.7)	42(44.7)
No answer	9	25	31

n.s. = no significant different in chi-square analysis

TABLE 8 FINDINGS FROM A SURVEY OF COMMUNITY AGENCIES

	Worcester n=101	Syracuse n=52	Rhode Island n=60
	# %	# %	# %
Are you aware that there is a specific project in your area dealing with elder abuse/neglect?			
Yes	78(78.8)	45(86.5)	43(75.4)
No	21(21.2)	7(13.5)	14(24.6)
No answer	2	-	3
If YES to above, indicate whether you hae referred a client to the project.			
Yes	42(51.9)	21(47.7)	31(64.6)
No	39(48.1)	23(52.3)	16(33.5)
No answer	20	8	13
If YES to above, rate the response you received from the project.			
Excellent	37(86.1)	13(56.5)	10(32.2)
Good	4(9.3)	9(39.1)	15(48.4)
Fair	2(4.7)	1(4.4)	6(19.4)
Poor	-	-	-
No answer	58	29	29
If involved in cases of abuse/neglect, indicate satisfaction with extent of coop-ration or coordination of services in your area:			
Very satisfied	31(68.9)	12(46.2)	12(35.3)
Reasonably satisfied	13(28.9)	14(53.8)	21(61.8)
Not at all satisfied	1(2.2)	-	1(2.9)
No answer	56	26	26

Dissemination Activities

1. Rosalie S. Wolf, "Preliminary Evaluation Results of Three Model Projects on Elder Abuse", paper presented in a Symposium on "Elder Abuse: Local and State Intervention Models" at the 32nd Annual Conference of the National Council on the Aging, Washington, DC, April 1, 1982.

2. Rosalie S. Wolf, Chairman and Organizer, Symposium on "Elder Abuse and Neglect: Preliminary Findings from Three Model Projects" Second Annual Meeting of the Northeast Gerontological Society, Albany, New York, April 29, 1982.

3. Rosalie S. Wolf, Cecile S. Strugnell and Michael A. Godkin, "The Nature and Extent of Elder Abuse" Region I AOA Education and Training Program, Gorham, Maine, June 7-9.

4. Rosalie, S. Wolf, Cecile P. Strugnell, and Michael A. Godkin, "Survey Findings From Three AOA Model Projects on Elderly Abuse", a poster session at the 110th Annual Meeting of the American Public Health Association, Montreal, Canada November 15, 1982

5. Rosalie S. Wolf, Cecile P. Strugnell and Michael A. Godk[illegible] "Testing Existing Theories of Elder Abuse" paper present[illegible] 35th Annual Meeting of The Gerontological Society of America, [illegible]on, MA November 20, 1982

6. Rosalie S. Wolf, Organizer and Chairman, Discussion Session, "Understanding and Treating Elderly Abuse: Reports From Three AOA Model Projects" 35th Annual Meeting of The Gerontological Society, Boston, MA November 22, 1982

7. Rosalie S. Wolf, Organizer and Chairman, "Working With Abused Elders", a training session at the 33rd Annual Conference of the National Council on the Aging, Detroit, MI, March 15, 1983

8. Michael A. Godkin and Rosalie S. Wolf, "A Profile of Elderly Abuse/Neglect in Massachusetts", a paper presented at the Annual Meeting of the north American Primary Care Research Group, Banff, Alberta, Canada, April 18, 1982

9. Rosalie S. Wolf, Organizer and Chairman, "A Training Session on Elder Abuse and Neglect", and presentor "Assessment of Community Needs, Resources and Barriers," 3rd Annual Meeting of the Northeastern Gerontological Society, Newport, RI, May 6, 1983

10. Pillemer, Karl and Rosalie S. Wolf, "Understanding Domestic Violence Against the Elderly", a paper presented at the 3rd Annual Meeting of the Northeastern Gerontological Society Newport, RI, May 6, 1983

11. Godkin, Michael A. and Rosalie S. Wolf, "Elders and Their Caretakers: Factors Leading to Domestic Elder Abuse and Neglect," poster session, 36th Annual Meeting of the Gerontological Society of America, San Francisco, CA, November 19, 1983.

12. Rosalie S. Wolf. Discussant, Symposium on "Using Research in the Improvement of Clinical Techniques for Assessing and Treating Abused Elders" 36th Annual Meeting of The Gerontological Society, San Francisco, CA, November 22, 1983

13. Rosalie S. Wolf. Discussant, Panel Presentation, "Delivering Services to Abused Elders: Report from Three AOA Model Projects" 34th Annual Conference of the National Council on the Aging, April 7, 1984, Washington, DC

14. Rosalie S. Wolf. "Findings from An Elder Abuse and Neglect Survey in New York State", paper presented at the 4th Annual Conference of the Northeastern Gerontological Society, April 27, 1984, Philadelphia, PA

15. Rosalie S. Wolf. "The Consequences of Judgmental Impairment Among the Elderly in Heatlh Care", address at Conference on "The Judgmentally Impaired Elderly: Candidates for Abuse and Victimization, May 10, 1984, Columbia University, New York, N.Y. (Appendix II, Exhibit 7).

16. Rosalie S. Wolf. "What We Have Learned", key-note presentation at "One Day Conference on Elder Abuse" Syracuse/Onondaga County Elder Abuse Project, Syracuse, New York, May 16, 1984.

17. Roselie S. Wolf. Presenter, "Elderly Abuse," Teaching Rounds. August 24, 1984, Worcester Memorial Hospital, Worcester, Massachusetts

18. Rosalie S. Wolf, and Karl A. Pillemer. "The Relationship Between Organizational Structure and Client Outcome in Three Model Projects on Elderly Abuse", a paper presented at the Second National Conference For Family Violence Researchers, August 9, 1984, University of New Hampshire, Durham, New Hampshire

19. Rosalie S. Wolf. Moderator "Panel on Elder Abuse." Second Annual Governor's Conference on Aging, May 23, 1984, Worcester State College, Worcester, Massachusetts

20. Rosalie S. Wolf. "Elder Abuse: Findings From Three Model Projects" a presentation at 85th Annual Conference of the New York State Association for Human Services. Fordham University, New York, New York, October 30, 1984.

21. Rosalie S. Wolf, and Karl A. Pillemer. "Model Projects on Elderly Abuse and Neglect: Organizational Performance and Impact", a paper presented at the 37th Annual Scientific Meeting of The Gerontological Society of America, San Antonio, Texas, November 17, 1984.